STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
CERTIFICATE OF NEED

CON COMMISSION MEETING
Tuesday, June 15, 2004
10:00 am - 4:00 pm.
MDCH Public Health Building #19
North Complex Baker-Olin West (BOW)
3423 North Martin Luther King Boulevard
Manty Conference Room 1B & 1C
Lansing, Michigan 48906

APPROVED TRANSCRIPT

MEMBERS PRESENT:

Renee Turner-Bailey (Chairperson)
Norma Hagenow (Vice Chairperson)
Peter Ajluni, DO (departed mtg 3:55pm)
Roger G. Andrzejewski (departed mtg 3:40pm)
Bradley Cory (departed mtg 4:00pm)
James K. Delaney
Dorothy Deremo (departed mtg 3:45pm)
Edward G. Goldman
James Maitland
Michael Sandler, MD
Michael Young, DO

DEPARTMENT OF ATTORNEY GENERAL STAFF PRESENT

Ronald Styka

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH STAFF PRESENT

Jan Christensen
William J. Hart, Jr.
Larry Horvath
Brenda Rogers

GENERAL PUBLIC ATTENDANCE

There were approximately 65 people in attendance.

CHAIRPERSON TURNER-BAILEY: Good morning. Now, I know all is right with the world, because if the mikes were working, I don't know if we could function in here. Welcome to the June 15th meeting of the Certificate of Need Commission. It looks like we have all of the Commissioners present. I would like to welcome everybody here today. We do have the agenda, and we were given a tentative agenda this morning.

COMMISSIONER SANDLER: I have a question, as to where the addendum that we were presented with this weekend, where that discussion would fall. I have a motion on the table and where was it intended?

CHAIRPERSON TURNER-BAILEY: I don't really have a question as far as where it's intended to be.

COMMISSIONER MAITLAND: Then where are we going to put it, item six?

COMMISSIONER GOLDMAN: I move to revise the agenda by adding to item six of Unity Health, the discussion of Special Bed allocation.

COMMISSIONER MAITLAND: I support that.

CHAIRPERSON TURNER-BAILEY: The move has been supported that we add to item six, the discussion of special bed allocation. Any discussion?

COMMISSIONER GOLDMAN: We can go over item six, special bed allocation, and then move everything else down one and then go over item seven.

CHAIRPERSON TURNER-BAILEY: Is that a modification to your motion?

COMMISSIONER GOLDMAN: Yes, it is.

COMMISSIONER MAITLAND: I support it.

CHAIRPERSON TURNER-BAILEY: It has been supported. Any further discussion? (No response). All those in favor please raise your right hand. Opposed, it's unanimous. Item three; Declaration of Conflict or Interest:

COMMISSIONER SANDLER: I'm referring any potential sale and conflicts of interest for Mr. Styka to comment on and not myself.

CHAIRPERSON TURNER-BAILEY: First item of business is the review of minutes from May 11, 2004.

RON STYKA: Did you want me to comment on the ethics?

CHAIRPERSON TURNER-BAILEY: You can comment on that now.

RON STYKA: Since the last meeting, the State Ethic's Board did not consider the issue that this commission sent to them, which involved the specific commission member issues involving Dr. Sandler and Ms. Hagenow and to their standard of the proposed act. The vote actually bailed on that, and it came up with a resolution. There's an opinion in the works and we do not have them, but I believe you have in your papers, the language that I quoted out in this resolution under the Conflicts of interest in your folders. The Ethic's Board, I argued that because of the language in Section 22211, I believe it is, which simultaneously says that the Commission shall consist of 11 members and it will take six votes to do a final action. That those 11 members come from a Murat of special interest. In the same section you are required to finally state a hierarchy that your prior bylaw provision, which is a little different from what the Ethic's Board's decisions have been for the last eight years, which was they had a direct penury or professional interest in a larger conflict that should have been adopted by the Ethic's Board and it might have had a statutory sections to do that by a section of the Legislation. However, the Ethic's Board decided to stay consistent with the past rulings and instead it was more narrow than that in their determination that even if your employer has a conflict, and the example is that last year the only two possible awardees of the change has been the standard that was proposed we're heading for and essentially a subsidiary of the system, that those were not a general applicability, and therefore, the employees had interest and that presented a conflict. However, they did create, I think in response to my argument, an exception. That exception was in the second paragraph that I gave you. That exception says that the member may participate in that general applicability to everyone, even if it is in the interest of the employer. It has general applicability and your employer or your hospital or nursing home or whatever may have an interest in it, but it's the same more or less interest as everyone else. So, they did open the door a bit. I have written a proposed bylaw that would encompass this change that I did pass out to you a few minutes ago. We can talk about that in the report, the bylaws. I don't think you're ready to adopt it yet. You can see the actual opinion from that. But the bottom line is that those are the governing principles. You should definitely keep them in mind and

you definitely should keep them in mind today as you deal with this. The standard is written in such a way that there's only your particular employer or a couple of the employers that qualify. You would have an ethical problem and there may be a conflict of interest and that's most important, but if it's a more general applicability applied on a broader basis you should not. Thank you.

CHAIRPERSON TURNER-BAILEY: Any questions?

COMMISSIONER HAGENOW: The only point that you did not make, Ron, is the fact that in my case, the employer is Genesys Health System and there's a notion that Essential Health has become my employer and they are the sponsor, and that they directed to achieve human resource clarification, and a check off list that they seem to feel was very standard out there. Which I haven't done yet because I also want to see the actual opinions but I think it would be an important issue from my perspective, in the sense that there's so many issues given the Essential Health of Michigan. We can have world issues and other issues that we have in Tawas, in St. Joseph's hospital and we have St. Johns, but we are a multi-billion dollar operation on a national level, and I'm tied together with the sponsorship, but my employer has always been perceived to be the Genesys Health System board. So, I need to get that clarified and I will. They suggest that I put that into writing because that would have bearing with me that I wouldn't declare a potential conflict, but I think that all of us on the Commission need to understand who is my employer.

COMMISSIONER STYLA: I think that we really need to look carefully at the exception of the paragraph. I think it's going to take care of most of your concerns.

COMMISSIONER SANDLER: Just a point of clarification. Tawas of St. Joseph is one of the 12 hospitals that did not change in rural MRI standards.

CHAIRPERSON TURNER-BAILEY: Any further questions? (No response) Thank you, Mr. Styka. Returning to review of minutes of the meeting on May 11, 2004. Are there any questions on this?

COMMISSIONER CORY: I have a few comments regarding my presentation. Just points of clarification. On page seven and line eight. "The other thing that's happening to this physical plans". Plans are the wrong topic. And line 14, clarification, "Also to the last restricted". It should be less. Line 18, "It would include assurance", rather than insurance. Third line from the end, "I feel that it must be compliant with the applicable designed standards". Page eight of 28, the top paragraph, fourth line, "Pilot programs", scratch was pilot programs. "Be duly certified".

CHAIRPERSON TURNER-BAILEY: I would like to ask the department to make those corrections. Any other changes?

COMMISSIONER SANDLER: Yes. I would like to apologize because I should have spelled the person's name. On the very last page, it says Commissioner Sandler. "I would assume Dr. Dusterson", and it should have been Gustaston.

CHAIRPERSON TURNER-BAILEY: Any other corrections to the minutes of the May 11th meeting? (No response). I'll accept a motion to accept the minutes with the changes made.

COMMISSIONER SANDLER: I make the motion.

COMMISSIONER MAITLAND: I second it.

CHAIRPERSON TURNER-BAILEY: Commissioner Sandler made the motion, and Commissioner Maitland seconded it. Any discussions? All of those in favor please signify with your right hands. Opposed? There were changes to the minutes of the meeting of March 9th. If you had a chance to look those over, I'll accept the motion if there are no further changes to accept the amended minutes on the March 9th meeting.

COMMISSIONER DEREMO: I make the motion.

COMMISSIONER SANDLER: I second it.

CHAIRPERSON TURNER-BAILEY: Moved by Commissioner Deremo and supported by Commissioner Sandler. Any discussion? (No response) All of those in favor signify by raising your right hand. Opposed, it's unanimous. Thank you. Nursing Home and Long Term Unit Beds. What is the status report?

COMMISSIONER CORY: The work group met yesterday and essentially finalized the recommendation with some changes. I would like to add that all of the participants were all there; the departmental staff, Health Care Association of Michigan representatives, Support Profits, and OSA group, the non-profits, the Continental Affair Facility and I think Larry Beard was there also and other staff. I'm very pleased that the group worked so cooperatively together to come up with some recommendations that seemed to make sense. So, I would like to have Jan explain what the current changes were so that this could be put before you today to take action.

JAN CHRISTENSEN: I'd like to start by thanking Commissioner Cory for working diligently on these particular standards. Long Term Care of Michigan is an issue of great concern. I've recently appointed a 21-member commission within the last week or two to take a hard look at the Michigan Long Term Care situation. A vital part of long term care in Michigan is the Nursing Home, a component of it. Although there's a great desire to build a continuum of long term care, everything from home health and city based, and a certificate of need and home community based labor, it's clear that nursing homes, a component of it will remain. For the future and make it part of the option of care need in Michigan. The difficulty that we've had is that the existing nursing home standards in the city has made it impossible to effectively and efficiently implement some of the latest designs for nursing home care. The Casolis Model, the Green House Models, these are national models that have proven to be very effective in providing high quality living, a better care for residents, a more desirable settings and monuments, and they have been proven to be extremely effective in other states. We had an internal executive branch long-term group that has been looking and kind of did some prep work, and there's been an Executive Commission that has been created, and it's very clear that across the nation where these models have been tried, there are significant improvements in patient care. So, the task force or the work group that Commissioner Cory has been chairing, which included, as he noted, he mentioned everybody that's involved in the associations of the nursing homes in the state of Michigan. The most that they've come up with away in which we could adjust to see if any standards to allow for building these new facilities. Now, admittedly there's always a bit of trepidation about wholesale change in standards, so the approach that has been tried is to open up a window for a year that will allow an organization for nursing homes to apply to renovate or rebuild or remodel a certain percentage of their beds. They've been limited to 100 beds each in the state, which is consistent with the literature that says that it's generally facilities of that size tend to work out a little better in quality care and management in the quality of life in those facilities. So, we've come up with an approach that provides, we think, a reasonable building standard with reasonable safeguards based on building codes and others. We've had an extensive involvement in the facilities here in the state and the building codes, to make sure that whatever adjustments we were making were still consistent with Fire and Safety and ADA and all the other issues that are important. We had the ability to allow Nursing Homes that are in the state to develop for this next four-year period, for these particular types of models. Our key component in this position of the standard has been improving the evaluation so that we can, the institute should be able to come back and report to the Commission. There are long-term care groups in the state and other interested organizations what we think has been a result of these solution valid things like quality care, safety, satisfaction family and care givers satisfaction with these new designs. This particular movement and standard does not deal with changes in finances. That's potentially another barrier that our colleagues in nursing home industry did point out to us that these facilities will not necessarily be less expensive than the current facility that we have, and that they may be a per diem cost premium that will have to be paid for admissions to be administered to these facilities. We're working on having this within a year for having a long-term facilities, the Medicare programs in the state, but that's a separate barrier. This barrier with the building standards, we're going to move forward. There is very little doubt with improvement towards the Green House models, the Ellis Models, and I believe with patients who need long-term care, and Michigan will be moving in that direction. It's just under this proposal we'll be able to do it. The pilot allows a significant number of those who are interested in our camps, who are into it and have conducted an evaluation, and then perhaps a number will recommend a broader and complete change of standards to allow this to happen. I'll turn it over to Brenda, who will go through some of the details on the standards.

BRENDA ROGERS: The first change that we're looking at in this standard this morning is part of your packet this morning. Commissioner's, you should have a revised copy that incorporates the changes that we made. Not a lot of changes from the version that was sent to you. If you could look at that copy that was distributed to you last week. Perhaps you can look at that packet that was distributed to you this morning. The first change that we're looking to make is on page seven, where we talk about the requirements for projects involving new construction and renovation. One of the barriers that got discussed was the street forum was the maximum room size in our current review standards. After doing some research and while I'm checking, it was discovered that the maximum square foot per bed was 450 is no longer needed. That was needed at one time. That was for Medicaid reasons. It's the department as well as the group's suggestions to remove the 450 gross square feet per bed maximum, but we leave the minimum standard in there. So, that's the first change. The next change, unless you have questions, if you want to ask questions as we go along then that's fine, and we'll answer them.

CHAIRPERSON TURNER-BAILEY: Should we look at the version that has the revision marks?

BRENDA ROGERS: You should have the ones with the revision marks. The only change, and if you look at the very bottom it will say "revised 6/14/01. Don't look at the other things. The next change is all the way at the back of the standards, which is the new addendum. I'm not going to read you every one of these, but if you have any questions as I briefly go over each section, that's on page 29. Section one deals with the definition that we use in this addendum as well as maintaining the definitions within the set of new need standards, but there are some new definitions for the addendum, specifically the new design model, needs for the new nursing homes or hospital for the long-term care unit constructed updated or replaced under the requirements set forth in this addendum, replacement beds being the effort proposed as to replace them is equal or less the number of beds that are currently licensed to the applicant, and license site means the geographic location specified on nursing homes or hospital long-term care unit licenses. Section two is used for the purpose for this kind of program and Mr. Christensen has already identified those to you. Section three gets into the components for applying under this pilot program. Again, as Jan stated, this pilot will be limited to four years, to add another four years and the conditions would have to come back and review this on whether or not they would want to turn this into, you know, to be part of the actual standard or in the pilot program. Sub two under that section deals with the design models for each of the facilities. Sub section A deals with those facilities that are designated. In some cases, well we've been assured that for that, but the mother pod sort of speak of some of these different types of programs. So those would be for the larger facilities. Sub section B is the design requirements for the smaller facilities. For the pod in some of these cases. Sub three deals with the types of rooms within the facility requiring that they be at least 80 percent single occupancy throughout the next room, and then the remainder of the facility, the facility will be replacing only a portion of itself and the remainder of the facility shall also include every presentable single occupancy rooms with the remainder of that not to exceed double occupancy. So, we're trying to move away from the formatted room facility. Sub section four deals with these additional requirements. It states that these facilities must be replaced or constructed within the replacement zone. If you want to do this outside of the replacement zone, then there are requirements that you would have to adhere to. Sub five just states basically that if there's a partial facility is replaced and it's replaced in a new location, then they will receive a new license. Sub six talks about the evaluation component that is Mr. Christensen's invention, that again is that the applicant will have to demonstrate at the time of application that they will participate in an evaluation with an organization of their choosing but have been approved by the Office of Services to the agent as well as the Medical Services Administration. Sub Section seven deals with quality of components. Basically what we are saying is that if a facility has not had a siting of substandard quality of care, then you have a problem forward. But if the facility or its parent or any of its subsidiaries has had one or more citations, then it will be looked at. And a subsidy of that sub section seven allows that entity to show that they are trying to come into compliance. It's not going to be completely stopped. There going to have the ability to demonstrate to the department that they are either in the process of trying to come into compliance or will be coming into compliance. This also, just to back up a bit, this is only in the previous 12 months prior to the application. So if they had citations two to three years before that, we're not looking at that. We're only looking at the previous 12 months prior to them submitting their application. We're looking at, like I said, the quality factor, trying to keep the quality nursing homes in compliance. Again, keeping in mind if they've only had maybe one citation and they're trying to come into compliance, then it won't be a barrier for them. Section four of this pilot are just

basically stating that they agree with the project delivery requirements contained within the standards, and there's some additional requirements that these facilities will be, or beds will be duly certified through Medicaid and Medicare codes. Also in Section five it deals with the acquisition of a nursing home or hospital with long term care units beds, that they have been previously approved pursuant to this proviso. Basically, again stating that if you're going to purchase one of these facilities that you have prior approval. You have to do it for the same requirements and conditions.

CHAIRPERSON TURNER-BAILEY: I had a question about the citations. How long does it take for a company for compliance following a citation on average?

BRENDA ROGERS: I'm not sure about that.

JAN CHRISTENSEN: It depends on what you suggest are citations. They are under a very short time frame to make changes. Typically there's a corrective action plan that was put together and those particular time frames we'll come back and visit to ensure that the corrective action plan has actually been put into place. Those very serious citations that are not typical, well, we'll go back and do another visit. I think that's more to determine our ability and our scheduling to get back out to do another visit. Of course we always handle the most critical rather quickly, so we might get back out there on a weekly basis or we might form a manager to be on site to watch the corrective action plan. There's a range of what options that we have to handle these citations. At this particular event, the thought was that if you're going to make a proposal to go forward on one of these innovative models, you must be able to resolve whatever deficiencies you are with the current standards before we can move forward on this.

COMMISSIONER TURNER-BAILEY: Any other questions? Commissioner Cory.

COMMISSIONER CORY: I just thought I would reiterate that the group worked very well together. The department fully cooperated and this was the enlightening for me because it's been my experience in prior years that they were very resistant. They appeared to be set up by a bureaucratic process because of the chronic lines of Medicaid valor that was worrisome. We all agreed that there's really no good time to do this. Since everybody would have liked to move forward and to put nursing homes to option themselves to improve the quality of life and the dignity of these residents, that we were able to move forward and I'm very pleased about that. There were long discussions, but we were able to compromise and I think everybody is very well satisfied. I will hope that the Commission approve this today so that we can move this forward to the public comment process. I'm sure there's going to be some public comments that can also prove helpful to us. So, I think that, if I may at this time, that there are no other questions or comments, I would like to move that this be adopted.

CHAIRPERSON TURNER-BAILEY: I just have one card on this. If you don't mind I'd like to take that before we act on your motion. Michael Perry.

MICHAEL PERRY: Good morning. My name is Michael Perry and I work with HCR Manor Care, Inc. We operate 300 nursing home facilities in 31 states, including 27 here in Michigan. As a multi-state operator, we had an opportunity to observe a variety of regulatory frameworks for nursing home facilities among the different states. We have reviewed the draft Pilot Program language for long-term care beds and units developed by the Long-Term Care Work Group, and we would like to offer our comments today. First, we wish to commend the CON Commission, Commissioner Cory, the department, and other Work Group participants for taking the initiative to examine regulatory and CON issues for nursing homes. It has been a number of years since there have been any modifications to the current CON standards. Thus, examination of the standards in the current regulatory climate for nursing homes is in deed appropriate. Second, we support greater flexibility in the CON standards for construction or replacement of new nursing home facilities. The draft Pilot Program language recognizes the need for more options for care delivery and would appropriately permit operators to construct nursing home facilities in Michigan that reflect innovations in nursing home care. Additionally, we support quality of care as an important objective for all nursing homes in Michigan. A regulatory framework that rewards high quality of care and penalizes those operators with a consistent record of substandard care is good for the long-term care industry in Michigan and good for the Michigan citizens. However, we do have some concerns about the draft language as well. First, we question why these changes need to be promulgated as a pilot program, and believe that similar

goals can be achieved through modification of the existing CON standards. The CON standards for the Long-Term Care beds have not been revised for several years. Thus, in our view, it would be more appropriate to conduct a "top-down" review of the CON standards with wide input from the industry. In our view, more study and consensus may be appropriate as to the actual issues facing nursing home providers under the Long-Term Care standards before moving forward with a specific pilot program. Additionally, from a procedural perspective, we have concerns that the proposed pilot program language do not receive wide distribution from our industry association, and that there may not have been sufficient opportunity for comments and input from a broad sector of the industry. We also have concerns as to whether the impact of some of the suggested Pilot Program language has been given sufficient consideration. For example, the four-year window for the pilot program appears to be completely arbitrary. It is unclear how this time period was determined. In addition, there's no upper limit on the number of new facilities that could be developed during the four-year period. This has the potential to significantly alter the location of nursing homes in many planning areas, especially those planning areas that are otherwise subject to the three-mile replacement zone restriction. This potential unlimited development of new nursing homes, outside of the standard CON parameters, could have a severe negative impact on existing nursing homes. The current standards impose maximum gross square footage limits on nursing homes that are outdated and inconsistent with today's care delivery and resident privacy expectations. These restrictions should be addressed on the substantive basis in the body of the CON standards, and not just on the pilot program basis. Both the State and the nursing home industry will benefit from review and modernization of the existing CON standards. We urge consideration of this approach instead of the pilot program strategy. Greater design and construction flexibility under the current CON standards- and not merely on a pilot program basis----- would enable all Michigan nursing homes to benefit by addressing utilization of existing space and by improving the construction requirements under the CON program for all new and replacement facilities in this state. Some of our other specific concerns include the following: First, despite the language in the draft Pilot Program, that states that the program supplements and does not supercede the current standards. In reality, the Program institutes a totally new replacement zone in urban areas than what is currently in effect. Under the existing CON standards, the replacement zone for urban nursing home facilities is three miles. The replacement zone for rural facilities is the entire planning area. The draft language, in fact, supercedes the existing three-mile replacement zone by permitting facilities which qualify for the Pilot Program to replace existing nursing home beds anywhere within the planning area. We are concerned as to whether there has been adequate study of the potential impact of this change on the availability of nursing home beds in certain areas in the state. We also are concerned with the potential impact of the expanded replacement zone on existing nursing home operators. Under the proposed language, a nursing home operator could readily replace existing beds from less economically desirable service areas within the planning areas or the need for replacement. We have concerns that the Pilot Programs language has the potential to leave certain areas of Michigan without sufficient nursing home beds ad to potentially reduce the quality of the available nursing homes in those areas. We are skeptical as to whether the governing body requirement in the draft language would impose a sufficient obligation to address this issue. Second, although we support a greater flexibility and innovation in nursing home design, we also have concerns that an existing operator could split an existing facility into multiple new facilities under the draft language. Although each new facility approved under the Pilot Program could have no more than 100 beds, there is no minimum limit on the number of beds in a facility and no restriction on the number of "Clone" facilities that could be created from a single facility. Replacement facilities under the Pilot Program are not limited to the "Greenhouse" concept, and new multiple "mini" facilities could potentially be sprinkled throughout the existing planning area. Further study of this concept is warranted for quality of care purposes, cost control, and the potential impact on existing providers in the community. We support additional study and industry input on this troubling aspect of the proposed language. Finally, we have concerns as to the requirement for design input post-CON approval by an agent approved by the Office of Services to the Aging. Although applicants in urban planning areas would be exempt from existing three-mile replacement zone, there is no requirement for approved applicants to incorporate recommendations of the OSA agent. Given that these innovative design elements appear to be the impetus for the Pilot Program, it appears that this should be a mandatory part of the CON application process and such input should be obtained prior to submission to the CON application. As an alternative to the Pilot Program, we believe the industry would be better served by an overall review of the CON standards and modifications to the existing construction requirements so as to benefit all nursing home providers and their residents. Amendments to the existing CON standards to remove outdated restrictions and to grant greater flexibility in design to all nursing home providers would provide greater

assurance that consumers would benefit from innovative nursing home design concepts. Basically in summary, we have concerns that the proposed Pilot Program needs further study and reflection given that the overall changes to the CON Standards are needed. More study of the problems under the CON Standards is appropriate with a broader base of input from the industry and more time to reflect on the issues raised by the current standards. We also have concerns that the draft language circumvents the current CON process for distribution of nursing home beds, and the replacement zone requirement. His would potentially have a material impact on the existing providers in certain areas of the state and adversely affect the operations of existing facilities. I thank you for your time this morning.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions? Commissioner Goldman.

COMMISSIONER GOLDMAN: Let me see if I can understand. Are you asking the Commission to not pass these on first reading, and to go back to the drawing board and re-work them?

MICHAEL PERRY: We would like for the industry to have more comment and we agree with what we're trying to do here. We just have some concerns and it's moving fast. We would like to have more comment from the Trade Association and providers as to the impact on the existing proposal.

COMMISSIONER GOLDMAN: You understand that there is a public comment period. We would go from public comment and then come back, you would have that opportunity. I'm just asking you whether you think that opportunity is not sufficient and you want to slow the whole process down?

MICHAEL PERRY: We would like to slow the process down. We do understand that there is a public comment and we would be very willing to provide that comment at that time, should the Commission feel that it is appropriate to move forward to the public comment, and we would like to be involved in that process.

COMMISSIONER MAITLAND: I wasn't sure, were you present at these review meetings?

MICHAEL PERRY: Our organization was not present, our Trade Association was.

COMMISSIONER MAITLAND: This goes to my concern. I know we worked hard on making major changes about this process rather than sending it to an Advisory Committee, lends itself to this type of problem. I don't know what the solution is, but it seems like this is maybe more of a major change than what we've indicated by just the two pages that we have in front of us. I'm not sure -----how is notice made to the investor for these review meetings? Did you close it yesterday?

COMMISSIONER CORY: That was our last meeting, yes.

COMMISSIONER MAITLAND: How is the state of Michigan applicants notified?

JAN CHRISTENSEN: We've got four, five-----

COMMISSIONER MAITLAND: How is that sent off to everybody? How does that work?

JAN CHRISTENSEN: It happens in a variety of ways. It works— we invited all of the major Trade Associations to participate, and their Trade Associations did participate. We expect the Trade Associations to be the dialogue with their numbers. We give concessions to the Trade Associations which we believe happens in large parts because we met on three formal occasions over a six-month period where we had them report back to this Committee, which we made reports and made copies of all the minutes to these meetings. Of course these minutes were put up on the web page. These went along with the long-term care standards. We accepted input from everybody that provided input even if they weren't on the committee. In fact, we had an open forum where anybody who wanted to come could present its information, they could do that. I think we accomplished functionally exactly the same level of input that you would have gotten with the Standard Advisory Committee. I think we also accomplished the same level of the situation. With regard to the one comment, if I may, that was made, a longer overall review of the entire Long-Term Care nursing home, the standard of regulatory mix, there is a staff that has been

formed to locate the whole range of long-term care issues. This Pilot Program is consistent with some of the occupants, but it is intentionally limited as to Pilot Programs because after over the next year when we took a look at the program range, we may make some changes, some expansions actually that would more likely to make these limitations very clear to long-term care. The members are interested in pursuing these type of innovative approaches. We think it's clearly consistent with the current efforts that are undergoing with the home care in Michigan.

CHAIRPERSON TURNER-BAILEY: Commissioner Sandler.

COMMISSIONER SANDLER: I just wanted to make a few comments. The AD HOC Committee, which I chaired, only had three meetings in three and a half months, and although this wasn't a state advisory committee, it does appear to have had approximately the same. It does also appear that your organization and other organizations did have the opportunity for review. It also appears to me that the following can be true unless the department corrects me after the public comment session, which should take place probably four to six weeks from today. It would be another six-week period until we meet on September 14th with Commissioner Cory, the department, other major players make any corrections in the public comment section. In addition to that, Commissioner Cory, the department in general could ask for an extension until December 14th if they chose to do that. So there's still plenty of ample opportunity for you to prove and to continue and not slow the process. We can still take action today. You still can bring appropriate points. I have to say that this is the first time that I've heard criticism that the CON Commission is moving too quickly. That generally has not been the comments that I've heard around the state, particularly about physicians.

CHAIRPERSON TURNER-BAILEY: Commissioner Deremo.

COMMISSIONER DEREMO: So, notwithstanding what Commissioner Sandler has said, as I understand it from Mr. Christensen, besides this kind of project as a draft, there are really two concurrent things that are happening. There's a review of the entire standard, which our speaker had requested, and that there's this Pilot language so that those things could be happening concurrently. So as the industry did not have to slow down making the kind of changes that they needed to do, but at the same time they looked at the overall standards to see how they could be brought out to be what we consider current practice. Am I understanding this correctly?

JAN CHRISTENSEN: That is correct. The Long-Term Care task force was in charge of looking at the entire regulatory environment, and not just the event that the licensure standard, but the issues with respect to Medicare, the waivers that we have on Long-Term Care, et cetera to see how it all fits together. How it's fits for Michigan, and then make some very concrete recommendations for the Legislative change if necessary, for Legislatures on the Long-Term Care task force. So, we're prepared to make some statutory changes, and we're prepared to make some recommendations for regulatory changes on licensure and some regulatory changes on these events. But that task force doesn't complete its work until April of 2005.

CHAIRPERSON TURNER-BAILEY: That's all we're going to hear on this. Are there any other questions or comments? (No response). There is a motion on the table to accept the language, and it has been supported. The motion is to accept the language that was put forth on the nursing home informal work group. Are there any other questions or discussion?

COMMISSIONER MAITLAND: Again, that is my concern, and I don't know how many other concerns there are, maybe it's just this one concern. By us moving forward, we're sort of endorsing the idea, as far as I'm concerned, so I will support it, but it concerns me that there would be this much questioning of moving forward.

CHAIRPERSON TURNER-BAILEY: I'm sorry, I just received another card. We're in the middle of a motion, but I'm going to give this person a chance to speak. I'll ask him to keep it brief.

CHARLES DUNN: Hello, how are you today. My name is Charles Dunn, and I'm in the nursing home business. I've been in it for over 20 years. I have two nursing homes left out of the four or five that I have

had over my lifetime in business. I'm really upset about this process that's taking place. I need to bring it to the Commission's attention. All of a sudden there seems to be this inventory of beds that's cropped up over the last few years. What my concern is, is that just because there's an inventory of beds, it doesn't necessarily mean that there's a need for new beds. There's been an alternative in place for years, for the last several years, for elderly people to use other than in a nursing home. The waiver programs, the Hospice Care, Assisted Living; all different kinds of alternatives. So, when we talk about the need for beds, let's talk about the actual need. I have a nursing home in Western Wayne County and I just found out recently that a large chain is considering opening up a new nursing home in Canton, which is about a mile or two away. When I bought the nursing home four years ago, it was a 236-bed facility. I reduced the amount of beds about a year and a half ago down to about 45 beds because I couldn't keep those beds occupied. I still have 40 vacancies. Now, all the nursing homes within five to seven square miles, maybe 10 square miles of my nursing home, none of them are running at 93 percent occupancy. So, while there may be an inventory of beds, where's the need? Where is the real need? What upsets me more than that is that I take care of mostly Medicaid patients. We on one hand have an 85th percentile rule that we have adhere to. Does everybody know what that rule is, because when I talked to Mary Horvath, she didn't know what that rule was. I was really surprised that everybody doesn't understand that when you're managing a Medicaid population, it has to be at least an 85 percent occupancy or you're penalized or your rate is reduced. On the other hand, you're going to give a chain operation that happens to be large in the country, an opportunity to build a new nursing home within two miles of me that has no intent to take care of Medicaid. So, now you're penalizing me. On one hand we have the 85 percent rule, and on the other hand we may give beds out to another provider. What's going to happen is my bed has to be-----is going to be further reduced. This is happening not only in West Wayne County, but in many counties in the county. I think this has to be looked at very closely. What I did was, I found under the--------I have a solution to the problem, but I'm concerned that it's going to get so out of control before the solution is acted upon, that it's going to be devastating to the industry. I'm not only speaking for myself at this point, I'm speaking for everyone in the industry. In the Psychiatric bed need, there's a section here, Section D that says that the average occupancy per all of the existing beds must be at 90 percent. Now why can't you apply that same question whether it's over-bedded, under-bedded, or through the beds. Why can't we apply that same rule? Because right now all you're going on is based on inventory. Inventory has nothing to do with actual need. I think that this has to be corrected. I have four actual copies of it for you to consider. If you can just imagine that about two months ago, a Certificate of Need was approved for an assisted living to put 40 sub acute beds in the assisted living in an area that's four miles away from my nursing home. It's no special population that we're talking about here. It's just that assisted living in now in the nursing home business. So, what are we going to have here? A bunch of poorly bedded nursing homes attached through assisted living. And that nursing homes that have been serving the community for 20 years are going to be faced with what? It's going to be a disaster. It is a disaster. My question is, is there any way to stop the process at this point other than a junction from a Circuit Court? Because I'm really concerned that with the inventory out there, there's going to be a flood of applications filed and it's going to cause, erect able harm. I just don't know where to go from here. I don't know what to do.

CHAIRPERSON TURNER-BAILEY: Mr. Christensen, do you wish to comment?

JAN CHRISTENSEN: This particular standard deals with long-term care in nursing home beds that are in existence right now. It doesn't matter about the inventory. Homes that have existing beds, if they wish to remodel will hopefully be in a different facility. The facility approach, the point that you made, it won't add any of that standard of authority. It won't allow non-allocated beds in the inventory to open up that otherwise would. It merely allows homes with existing beds to decide where it wants to go. It's up to the facility to provide one of these innovative models. I would agree that the rest of the standards does need a hard look, as the other speaker has said, and we're in the process of doing that in the next year. We're trying to get some definitive changes.

CHAIRPERSON TURNER-BAILEY: Thank you. Any other questions?

COMMISSIONER MAITLAND: Did you attend any of these meetings?

CHARLES DUNN: I was not notified.

CHAIRPERSON TURNER-BAILEY: Any other questions or comments? (No response) Thank you. There is a motion on the table which has been supported to a specific act prior to this issue, and I'll consider that part of the discussion, but if there's any further discussion, then we would like to hear it now.

COMMISSIONER MAITLAND: If this is approved to go to public hearing and the public comment is held before next week, then it would come back to us and we can continue discussion; is that the plan?

CHAIRPERSON TURNER-BAILEY: That's right. I urge anyone with concerns to make sure that you attend the public comment meeting and make your concerns public at that time. I have seen standards make changes as a result of the public comment session. Any other questions? (No response). All those in favor of the motion, please signify by raising your right hand. Opposed. It's unanimous. Thank you, Commissioner Cory. We thank you for your time and your efforts. The new Item Six, Special Bed Allocation. We did have language received recently and we have copies here this morning. I will ask the department to give us a brief description. It doesn't have to be brief.

COMMISSIONER MAITLAND: Sometimes brief is better.

COMMISSIONER SANDLER: The Piston's game is at 9:00.

JAN CHRISTENSEN: Some time over the last several meetings of the Commission, we had another Item Six on the agenda, and that was the Unity Health thing where a particular group of individuals from Detroit who were in interested in reopening the facility. On that occasion the Commission, I asked that the item be tabled. I am aware there was significant discussion going on. The department was formulating its own parameters under which you can consider this issue and began to do an internal review. I hoped to have been able to attend this proposal so that we could react to, but we didn't get one. Nonetheless, we completed our review in the last week or so of what we thought the intended parameters would be. The Governor has said on a number of occasions that she supports the program. I think the standard in front of you accomplishes that. You can now add a single bed to a statewide inventory of operative beds. It Instead utilizes the existing beds that could be used. The Governor has said she's interested in a level of flexibility in this program to deal with critical needs that will come up. I think that's a reflection of her impression, that the bed need methodology and the sub area designs of the Commission has proved and came before her and she did not appeal, but she may have, but was the best example that was reported by the people that worked hard on that standard to come up with a design, but that was not 100 percent perfect. I think even the advocates would say that it's not perfect on the bed need methodology and design. At the same time, the Governor has been concerned and we have reported to you over the last year that there is an increasing crisis in the urban hospitals in this state with respect to pay mix. We have seen the Medicaid case load increase by 35 percent. That's a 35 percent increase in Medicaid case load. That means that there are a proportionate, almost a proportionate decrease in the number of people who run commercial insurances and Blue Cross/ Blue Shield insurance. And there's also an increase, some portion of it will be an increase for people who don't have insurance at all, in compensated care. We have an increasing problem with the payer mix in the urban hospitals. As we began to look at that issue, our desire to address that issue in some meaningful way has taken a number of approaches. One approach is that we've worked over the last year to develop a Detroit Health Authority with the City Counsel in the last week or so has improved. We expect that the Commission will put this issue on the table in the coming week. We helped the Detroit Health
Authority to organize care for primary care and Medicaid eligibles in the city and others to provide service for uncompensated care in the city. We've taken that action and worked hard to get the city legislature, and the county and the city to allocate supplemental funds to the Detroit hospitals primarily. To cover some of the stress of the experience of financials of those hospitals. I think that we've done about all that we can do. I can tell you that in the very near future if it's not already an issue, that there will be an issue, an Executive order issue reducing the state's budget with respect to provider rights and with respect to some aspects of the coverage. The state is in an extremely distressful situation to go back to the state for additional money to supplement our health or make an allocation in these urban hospitals is not a viable option at this point. There is no more money left in the till. We are trying hard to get some additional revenue enhancements. The Tobacco tax passed on the Legislation, and many of you are familiar with the difficulty that we are experiencing to get that done. There are two other major pieces to the Governor's '05 budget that are on the line as well. There's a couple of the state's taxes which is 95 million dollars, which

they don't seem to have anyway, so the Legislature support or very little Legislature support, certainly not enough to pass at this point and time. So the state budget is an extremely tight situation, and it's not open with the department. It is clearly unlikely they'll allocate additional state funds. One thing that we can do for the urban hospitals at this stressful time, is to allow some movement within the program that would improve the pay raise. Since we looked at this issue we decided that a limited pool could be created, about 2 ½ percent of the total number of licensed hospital beds in the state. That 2 ½ percent on the inventory as of January 2004 would be about 684 beds that will be allowed to move under this pool if the standard was recommended by this Commission. The 684 may seem like a lot of beds to move, but at least we put in the prospective that in January of 1993 there was 32,967 beds in the state. About 10 or 11 years ago there were 17,967. In January of 2004 the 27,353, effectively in that decade Michigan has lost 5,643 beds. This standard would not add any beds back to that 27,353 beds. It would allow 684 new beds. We felt this process was better than some of the other standards the Commission has had to consider in the past. It allows any of the urban hospitals in Detroit, and the Metropolitan counties in the state to submit applications to move. It has established material based on a number of Medicaid eligibles. That will contribute care to the urban areas. Based largely on that with an adjustment of another criteria that it's related to the positive benefits that could be achieved by a more diverse payer rate. In the event that the movement of the events against the attraction of the increased number of Medicaid eligibles throughout the state. It also adjust for the dedicated young subsidies and resources that are already allocated through some urban hospitals. Certainly not all of them. It would allow, of this one time pool, to move that to create new hospitals or the withstanding existing hospitals to improve pay mix and to improve the facilities. It also takes into account the closure of urban hospitals. We've seen a significant amount of closures of hospitals, largely that 5,614 beds that have come off line in the last decade. It should increase the hospital industry in testate and also the population has increased due in a large part to innovations of care and shortened hospital stays, expanded use of outpatient care, all good things, but nonetheless an overall shrinkage of the hospital who had urban hospital closures. In our largest metropolitan area in the state, particularly in cities over 750,000 population. Which at this time there is one. It will allow the creation or reopening of a hospital that closed in that city. By putting 200 active beds will each be moved within that city so this would not have any additional beds for that city, but it would be added upon the hospitals in that city to work together to move the active beds in order to open that communities hospital to reopen. So it does allow the movement of beds. There's no question about that. One of the factors under that would be the reopening of a community hospital. The cost should not be more than the cost of reconstruction to reopen that existing facility. There's a limitation of the cost of the expansion. Under those circumstances we think this is a reasonable approach. We think it has several advantages over the other standards that have been in front of the Commission. The standards that allow the policies to move. The policies to allow the upper bed capacity to shift to another hospital. Some of the other standards that are in front of this committee, we think it has advantages because it allows a variety of hospitals to apply and the number of applicants is unknown, but we will let those applications comply. We'll evaluate those applications against the current criteria, and the ones that best meet the criteria we will allow them to move. We think in that sense it's in the policy. It plays a fidelity at the level of 97.5 percent with the standards related to that movement and is consistent with the Governor's strong feeling that we need a strong see of that program. That we need a little bit of flexibility to take into account these very dramatic difficulties that we're having in the financial support for urban hospitals in the state and the support for the commitment of the urban hospitals. If you have any questions, I'll be happy to answer any questions.

CHAIRPERSON TURNER-BAILEY: Any questions? Yes, Commissioner Andrzejewski.

COMMISSIONER ANDRZEJEWSKI: Jan, you indicated that this proposal limits the potential movement of beds to 684?

JAN CHRISTENSEN: That's correct.

COMMISSIONER ANDRZEJEWSKI: How is that number arrived at?

JAN CHRISTENSEN: That actually is a reflection of 2 ½ percent times the total number of beds licensed in 2004.

COMMISSIONER ANDRZEJEWSKI: That part I understand, but why isn't 1 ½ percent or four percent or six

percent. Where does the 2 ½ percent come from?

JAN CHRISTENSEN: The reflection of the overall increase in the Medicaid population. We played with some numbers and looked at the potential impact of the differential and Medicaid payments with a certain part of the payments, in terms of residents, and it came up to a very close number to that. So the 2 ½ percent was total.

CHAIRPERSON TURNER-BAILEY: Commissioner Young.

COMMISSIONER YOUNG: In Section two where it talks about the different types of criteria. Are they going to be weighed by point systems, or how are they going to be weighed?

JAN CHRISTENSEN: These criteria's will be waived equally as it indicates. It turns out to be a ranking based on the applicants who we receive. So if we have three applicants, and one has the highest number of Medicaid eligibility under the first criteria, they get points on that. So it would have basis of an absolute ranking. Each of them will be weighed equally. We're going to run down each criteria and the one that has the most number of eligibility would be the proposal that will be funded with the allocations approved, and then the next and the next and so on.

CHAIRPERSON TURNER-BAILEY: Commissioner Maitland.

COMMISSIONER MAITLAND: Yes, Commissioner Maitland. Mr. Styka, you probably had a chance to review this. Is this put in a way to be put forth subject to comparing the review?

RON STYKA: Some day the state budget will improve and we'll have our own mikes.

COMMISSIONER SANDLER: Only if the cigarette tax passes or I die and you get my inheritance.

RON STYKA: The way this is structured, and I did get a chance to look at it. The way that this is structured, the criteria under Section two are actually A through E. They asked us to compare the criteria. So you don't get to have A through whatever, unless you need to, to compare the application. That's the way it's listed. It is definitely subject to review with, but things are only subject to compare a review when you get more applications than you have rewards sort of speak. So if there are more applications than the 684 beds, then you have to go to some part after that. You have to look at the criteria and weigh all the applicants.

COMMISSIONER GOLDMAN: In the graph, Section two says, "the department may create a one time available allotment". In another section in Section two it says, "the department can approve only one application from the hospital or the community health system". And then finally in Section three it says, "the department may create one time available allotment, 200 beds", and in Section four it says, "establish an application submission period". Is it a correct interpretation to say that anyone that only apply and we granted this exception once, and the application has to occur within a limited time period that the department will establish for submission?

JAN CHRISTENSEN: That's correct.

COMMISSIONER GOLDMAN: So, if you established a 30-day period in November, any number of hospitals can apply, but if they've had an application that has been accepted, they can't apply again if you've had an application that wasn't accepted, and there was another application period, then they can conceivably apply?

JAN CHRISTENSEN: That would be correct. I had more than one approved per applicant.

RON STYKA: There is a separation between Section two applicants and Section three.

COMMISSIONER GOLDMAN: Although it says in Section two that they intend to move beds out of the area, and Section three seems to be establishing bed need methodology. And the core of the question is,

and I think you would agree with this, this would fit in bed need methodology because this was drafted as a general livable standard that would have handled things like hospitals that have high occupancy and things like changes in demographic populations. Is that a fair statement?

JAN CHRISTENSEN: I'm not sure about the specifics of the Metropolitan transfer. Generally it would allow hospitals that have adverse payer mix because of the increase in numbers of the Medicaid eligibles, and the most egregious of that. It would allow those hospitals who apply and the city and the authorization to move a limited number of beds on those basis.

COMMISSIONER GOLDMAN: What is interesting to me about this approach is that it is a special bed application and we have a SAC that is set up to look at, a Standard Advisory Committee, that is set up to look up bed standards, so will these ideas go forward so that we can evaluate need and excess for a statistical area in the state and try to come up with a broader solution or a broader approach to deal with these problems in the future? My particular thing is that we are going to see things like the increase in Medicaid and we're going to see changes in the demographics, and we're going to see the aging in the population, we're going to see other arguments that we make for changes in locations of facilities that serve the Michigan population that is applicable to this approach. We'll move forward to our Standard Advisory Committee?

JAN CHRISTENSEN: The Standard Advisory Committee was charged by this Commission to look at acts of the care givers, and that's an area that we're looking at with that Commission. We've been working together with some date for that Standard Advisory Commission. We have it on the agenda later. We haven't been able to gather that data quite as quickly as we like to. We've had meetings with MSU, Charter through the department, and we've added some changes on some of the issues. We've been looking at some issues with respect to land and we expect to that. Whether excess issues are related to travel distance times issues, population changes throughout the state, and we've seen some declines in some populations and some urban areas we've seen increases from the last couple of decades. So, it's our hope that the Commission Standard Advisory Committee will look at those issues over the next six months and make some recommendations related to the geography. This particular standard is related to a financial standard related to later events, and there's been an increase in liability for urban hospitals in light of the crisis that we are currently facing.

COMMISSIONER GOLDMAN: If this is a financial standard issue, I guess my concern is that as a Commission, we are charged with looking at demonstrations of needing and excess. I thought that's what Section one was about, to address critical problems of a 35 percent increase in Medicaid eligibles that were in hospitals. Where does this fit in with our broader mandate of demonstration of, giving you demonstration of need for excess to these homes?

JAN CHRISTENSEN: I think we sent that as well. I think there's a section in the 6/19 that relates to the standards related to the financial issues related to the Constitution. This is the recommendations for that particular standard. I think that this standard relates to excess to the three steps down the road. As you can it continues to have closures and financial installments in urban hospitals. Ultimately you have an excess problem in the urban areas. It has testimony from the Commission. It has been presented over the last couple of Commission meetings. Some folks may still consider it licensure and excess right now in terms of that application. But what this does though is that the front end includes financial liability and allows improved pay events for hospitals in the urban areas who are carrying the bulk of the Medicaid case load. We think that's the reason to allow them. We systematically plan to do it. We think we should do it under the review basis, it's part of the standards, so that everybody can rule on it. We should measure it in a limited way if it's not increased for the total number of beds.

COMMISSIONER TURNER-BAILEY: Commissioner Ajluni:

COMMISSIONER AJLUNI: Mr. Christensen, just one question. In Section three regarding the emergency department. The language, help me interpret it. It includes provisions for the emergency department. Does that mean some time in the future? How is that interpreted? Does it give a time commitment? Might it be two or three years down the road? How is that interpreted?

JAN CHRISTENSEN: That says one thing definitively in its provision. That if you're going to make an application, you have to have a definitive plan under this as a red line criteria. You have to have a definitive plan for opening an emergency room. I would expect that we would hear comments if this gets to the public hearing point of view for as far as final adoption that we would want to put a time limit on that. We didn't do this because we're comfortable that there's a definitive plan and typically for us to see it again, that's a three-year window when we plan things out. On the other hand, if the application comes in and says we're ready to open the emergency room today and another application comes in and says we're open the emergency room in three years, well, ranking orders and the Federal review, the one that's ready to open the emergency room the quickest will most likely get that right then.

CHAIRPERSON TURNER-BAILEY: Commissioner Maitland.

COMMISSIONER MAITLAND: Yes, I appreciate the department's effort in putting this together, but I just got in on Friday, and I think I heard that some Commissioners received it on Monday, so I don't know if we had adequate time to review it, and also based on the discussion even in our prior agenda item on Nursing Homes, these things need to be reviewed and thought out very carefully. So, I would move that we refer this addendum to our Standard Advisory Committee that we did established at our last meeting to discuss excess. I think this is an excess issue. In fact, everyone has been arguing that point for the last two years with us, as far as I'm concerned. They are mandated to move quickly and I think this is a major decision and I want to have everyone be able to have their input into it. I'm going to support this addendum. Again, I move that this be referred to a Standard Advisory Committee report.

CHAIRPERSON TURNER-BAILEY: It's been moved by Commissioner Maitland and supported by Commissioner Deremo to move the language that was presented to us today, to look for a review by the Standard Advisory Committee. I am going to take public comment on it prior to discussion. I'm going to ask for leeway in that, and maybe we'll ask for discussion on the motion and vote. Mike Duggan.

MIKE DUGGAN: My name is Mike Duggan and I'm the CEO of the Detroit Medical Center. It's been six months now, which has been quite an education. My education has continued this morning. I got a chance to take a look at this yesterday, and I appreciate the opportunity to at least give you some of the concerns that the DMC has. I think that everybody knows last year when the DMC was on the verge of a closing of Hutzel and Receiving hospital, the state of Michigan, the county of Wayne, and the city of Detroit came up with a 50 million dollar mail all package which ended last month. It basically was an agreement with the DMC to keep those hospitals open, to give us some breathing room to change management. I know you followed the media coverage. We've had a 75 million dollar turn around in our bottom line. Last week the rating agency upgraded our outreach from unfavorable to stable, and I believe they're about to upgrade up again to favorable. We're within striking distance next year of a balanced budget and operating in the black for the first time in a long time. There's been a lot of hard work in cross cutting and building volume. The one thing that I have been insistent on that if you look, and I've been through the files for the last six or seven years, and the DMC is always one step behind reacting to the latest crisis. What we have done for the last six months is not just deal with our problem today, but look at where we are going to be in five and ten years. That process is being led by Mr. David Ellis, whose the editor of the Healthcare Futures International magazine. He has come in and continues to focus on where is medicine going. The point that he has convinced all of us on now is that the future of a healthcare system is not in bricks and mortar hospitals. It has-been quite an education for us. When you look at what's happened in interventional Cardiology, and the progress was made literally by the months and by the way open-heart surgeries have been reduced. And now we're looking at heading into interventional stroke cases. If you look with what's happened with minimally invasive surgery, the ambulatory surgery centers, and now the new wave, Chemosurgery. People are going to be staying in hospitals a lot less. The advances that are being made in Cancer treatment on a monthly basis, that if you start to look five years down the road, the point that we're looking at is that we have evolved beyond a bricks and mortar operation. When this came up and I saw that there was a proposal that looked like it might be going forward to spend more than a half a billion dollars to construct 600 or 700 new beds in three different locations, my first reaction was that this is right. I've read these G-dact reports that we're over bedded. I read the Economical Alliance reports that we're over bedded. David Ellis tells me G-dact and Economical Alliance is wrong. They are a snap shot in time, but the way medicine is going, there is going to be a dramatically fewer beds needed. When you hear that we're down from 32,000 to 27,000, that's the progress in the line that we're on. I thought when I heard this

that it must be a product of the CON Commission analysis that shows that Ellis and these guys are wrong. That, in fact, there is a need for more hospital beds and we should be investing it. It's the way that medicine is going. I've been asking for some kind of analysis, some kind of a report to indicate that there's going to be a need for more buildings. When I'm told that this was an Advisory Committee, which Dean Christian is on and have been telling me about, that is looking at these issues, but at least from his perspective they haven't reached any conclusions that there's going to be a great increase in the need for beds. And so my first request would be to say that you are making a decision on this issue that will effect health care in Detroit region, 10, 20 to 30 years out. I would hope before you do it that there actually is an analysis as far as the direction. What does it mean to DMC? It is extremely disturbing. Our Board of Directors had an emergency meeting last night and unanimously voted to oppose these standards and asked me to come and convey personally their strong feelings. We have within the 10 possible hospitals and institutions in the DMC two that are really profitable; Children's Hospital and Huron Valley Sinai in Commerce Township. This year Huron Valley Sinai is going to make somewhere between $6 and $8 million dollars. It is absolutely essential to our long-term profitability. It has about 160 beds, and on a given day 110 are occupied. If we go down to 100 occupied, we'll break even. If we go below that then we'll lose money. You drop two hospitals with 500 beds within 10 miles of Huron Valley Sinai, what do you think the chances are we'll lose 10 beds full of occupancy. Our analysis is that we'll lose a third of them, and you have now put yet another DMC institution which was pouring every nickel it makes back into helping in Detroit. You're making another one unprofitable. As I look at the history here, I had to look at this and I said, "DMC signed on to support this Legislation in December of 2002". What in the world were you guys thinking? They hand me a signed contract signed by the presidents of Henry Ford, St. Johns and DMC, May and December of 2002 that allowed the Legislation to go forward and get us there. Do you know what that signed contract says. That signed contract said that Henry Ford agrees as a part of this deal that they will be pulling out of OB services and those would be consolidated at Hutzel Hospital. So what DMC was looking at when they agreed to this was, maybe we'll lose the $6 million dollars at Huron Valley, but our primary mission is to keep Hutzel open. If we can get the volume into Hutzel, DMC will come off, and it makes good sense to consolidate the OB services in Detroit, et cetera. I sat down with the president of Henry Ford a few months ago and took the signed contract and said you guys aren't moving the OB services, and the president indicated to me that "we've re-evaluated that decision and our doctors won't like it and we're not going to do it". "What do you mean you're not going to do it, it's here it's in writing and it's signed. It says, "Why we agree to the legislation of the deal", and in a very professional implied way, she said, "Mike you do the health care and you'll learn". The bottom line is that they have flat out reneged on what caused DMC to go along with the Board, which when it supported in 2002 was told that this deal was done. Now it recognizes that it's a terrible situation all the way around. I was going to speak, in fact, I was here to speak in favor of the Unity Proposal until Dr. Ajluni asked that question, and now I'm horrified about that one too. The Unity agreement-----I don't know how many friends on the east side of Detroit, how many Legislatures have come to me and said very passionately we need an emergency room in that part of Detroit. They have lobbied heavily, and I agree with them. We do need it and I support it. I thought when I saw the language that this was going to provide the emergency room that they need. Dr. Joe is an outstanding businessman and has been around recruiting doctors who are at Harper Hospital and have insured patients in our hospital to say come on over. That's God bless him. That's perfectly fair and reasonable. If they open up Unity and they are taking their mix of uncompensated care in the emergency room and our insured customers from Harper, that's the way it should work. They have the revenue offsetting the uncompensated care. That is right. If, however, and when I heard about the year thing, that's really disturbing. You allow them to go pull 100 paying customers out of Harper Hospital without any ability to get people with uncompensated care in the network without any emergency room. You've now put a hospital that would have made $2 million dollars, also down there. If Unity is opening their emergency room day one, I am 100 percent in favor. But nothing can be more destructive to the future of Harper than allowing the insured medicine beds to be pulled out without no comparable revision for uncompensated care. If I could just say a few things about the criteria itself. I have to tell you, listening to the explanation that the Attorney General's office and the department about what the criteria said and reading them myself, I thought we were on two totally different worlds. The explanations that I heard, I wrote them down as they said them. That it was the deal with the growing Medicaid caseloads. That it was the deal with the unfavorable payer mix. That it was to deal with the problems in financial standards. That's what these criteria are. Well, guess what, there's nine criteria. The nine criteria are weighed equally. How many of those nine do you think give any weight to the same Medicaid patients. I'll tell you, one. Only Criteria C, which says that they will weigh positively to present it to Medicaid patients. Criteria A, they give you credit

for being in a county with a lot of Medicaid eligibles. Not foreseeing them, but for being in the county. In B, they give you credit again for being in a city with a lot of Medicaid eligibles. They don't give you any credit for seeing them. They give you credit for being there. Which means they give you twice as much credit if you are in the city and you managed to policy wise wall yourself off from the Medicaid. You get twice as much credit than if you see them in C. Then we go to D. This is the stuff that I love. This is supposed to be general applicability, right? They will count it against it if you receive the direct governmental subsidy. DMC for all practical purposes is running a public hospital at Hutzel. It is 85 percent Medicaid. It is a public hospital. We're going to lose $40 billion dollars on $80 million dollars of revenue at Hutzel this year and we're struggling to keep it open. Because the state health doesn't help in the short run, to run one of the essentially public hospitals, I assumed that when I read this that we were going to get credit for doing that. No, no. Do you know what it says here? It says, "the lower amount scores higher". Which means we are penalized for what we're doing at Hutzel Hospital. It seems somewhat inconsistent about helping on a caseload. When you get to E, E, the amount of disproportionate share payments. When do you get a disproportionate share payment? If your hospital like Receiving is upwards of 30 percent Medicaid or like Hutzel that is upwards of 85 percent Medicaid. You get a disproportionate share payment because you are seeing far more Medicaid patients. It doesn't begin to cover our cause, but at least keeps us from going broke. Those are the hospitals to get. The ones that get disproportionate share of payments are the ones that see the most Medicaid people. Do we get credit for seeing more? No. The lower amounts scores higher. They score us down for seeing more Medicaid patients. Somewhat inconsistent with the explanation that I heard. My favorite one is Criteria I. They give you credit for closing hospitals in the last five years the greater number scores higher. So, here's what it is? We have Hutzel and Receiving open and continue to do so. St. Johns closed Southeast. I don't dispute their decision. I understand the pressures. But because they left that community and closed the hospital they scored higher and get to open in the Suburbs because we hung in there and stayed open, we score lower. I had my CFO on the way up call, and he said, "Mike, I want you to know this". He said, "if we close Receiving and Hutzel tomorrow, our dish payments go down, our closure points go up and we can get all 500 beds that are eligible in Oakland County. That's the proposal that has been placed in front of me. Given the rich tradition of this Commission in reviewing need or where this genuine need is and for making sure that the uncompensated care in this state is provided, I can't imagine anything more malicious and destructive than this proposal. I can tell you the reality. You almost have to have willful alliance to support this because here is what's going to happen. We get up to 2008 or 2009, and if every analysis is right, you have two beautiful new hospitals in Oakland County except their need for beds is way down. They'll say back in 2004, we sincerely meant to keep those hospitals open in Detroit. But given the fact today that we need dramatically fewer beds, when are we going close, the brand new ones that we just built. You can guess the likelihood of that. There's going to be somebody standing in front of this room in 2008 or 2009 saying we didn't anticipate the changes in medicine, we just had to close down those Detroit hospitals, and people will look back on this decision as what paved the way for that to occur. It is a terrible thing to abuse your medicine in Detroit, and I respectively urge you to ask your Advisory Commission to analyze this and see if anything that I've said here is correct. I have a feeling that their going verify an awful lot of it, and when they do, I think the decision on this would be obvious. Thank you very much, Madame Chairperson.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions? Commissioner Hagenow.

COMMISSIONER HAGENOW: Just one point about the decreasing of beds. I guess I see that very dramatically in Flint, Michigan where four hospitals and we reduced by 400 beds. Fifty percent of the beds went down. But it required building a new setting where by you can have private rooms and so on. How do you equate the fact that, yes, it's going in a descending line in terms of total number of beds, but it requires a different model. The old geography, the old buildings don't work to be able to do that. You can't do that in 900 beds. We would be struggling in Flint if we had 900 beds to handle the capacity of a community, but we can do it in a new setting. How do you facilitate that?

MIKE DUGGAN: Commissioner, you are asking the question. I wish you were in our strategic planning meeting. We all have capacity in our hospitals in Detroit. How do you get away from the double rooms to the single rooms within the space that you have on your current ground? I think our first obligation ought to be that we have to do exactly what you're saying. People do want private rooms, and that is the trend. But we have space in our buildings, these hospitals in Detroit, and there's a reason that people want to move them out and they're able to give them away. It's because they're not currently occupied. What if we put

the same money into the same space and went down from double rooms to single rooms? Could that be done? Those are things that I think this Commission should be looking at. Those are excellent questions.

COMMISSIONER AGENOW: My understanding is that in most cases when you analyze that, it'll cost more. So, you're putting additional fix cost into a present setting that may not be responsive to the larger movement and so and so. The consideration of being relevant of where you do the remodeling does seem to make sense to me.

MIKE DUGGAN: Here's the thing that I find hard to believe when they say the remodeling cost a half a billion dollars, but even if it did, here's the thing that we have to think about. You're going to wake up one morning in 2009, if all the new modern private beds are sitting in the Suburbs and the pressure that you and I agree is current, where is that cut going to come from? It's going to come in the area where the Medicaid population and the uninsured are. There's where we're leaving ourselves if we allow this to happen. I agree with everything you're saying, but I guess it's your role to figure out five years from now how will you ensure this care.

COMMISSIONER HAGENOW: One other question on a big macro circle though. It seems to me that we keep struggling to create standards for two different environments. We're trying to create a standard for the communities where the population is going. Where the customer service and the ecstatics are very, very important, and it's competitive. Clearly, it's competitive. When we speak in terms of Downtown Flint, Downtown Detroit, any one of these inner cities, it seems it has to be a public answer in some way, shape or form. I am struggling with the fact that we're trying to create standards for both, and I'm not sure that there is a way to resolve that with one standard.

MIKE DUGGAN: You may be right, you've been at this longer than I have.

COMMISSIONER HAGENOW: I'm fairly new at this too, but I think that we should be thinking about that possible principle, and that it is different standards based on these two main environments. In the competitive market, as you know, sometimes that is the best indicator of driving down cost and improving service where people will pay. But it certainly isn't the answer in the public good where a large population of Medicaid. If that principle is true, then what we've said about it is an impossible task and we would have to go back to thinking in terms of standards for two different populations about environments. Maybe there's somebody out there in the world that has done that, I don't know. It's commentary more than a question.

JAN CHRISTENSEN: I just wanted to make a point of correction. Standard I, does not refer to closure of a hospital by the average of inflation. But they refer to closures within the county. So if any applicant from that county ------

MIKE DUGGAN: I see, I apologize.

JAN CHRISTENSEN: And the other issue that Mr. Duggan raised is related to something that might happen in five years from now. As I've indicated in my testimony, we're necessarily concerned with what happens almost immediately. Nonetheless, the department has the ability to put stipulations on these applications to carry out these current standards, so if it's the intent of the standards to maintain an urban presence, and at the same time improve the payer mix to move those hospital beds, it would be a relatively simple matter to put this situation better so that the eventuality of what Mr. Duggan is projecting does not happen at the exact time.

COMMISSIONER MAITLAND: And you're volunteering the state resources to support those hospitals if they were in compliance? Never mind.

CHAIRPERSON TURNER-BAILEY: Thank you very much. Any other comments or questions? (No response) Dawn Williams. While Ms. Williams is coming forward, I'm going to give you advance warning that we're not going to get through all of the cards before lunch, so some people will have to wait. I am going to ask for an abbreviated lunch period though so that we can go and have our lunch and get back to work.

DAWN WILLIAMS: Good morning. I will be brief before lunch. I'm here representing Daimler Chrysler and my name is Dawn Williams. I'm soon to be a utilizer of healthcare, as you can see. Currently I'm the manager of Legislation in program initiatives for innovated healthcare and disability at Daimler Chrysler. The purpose of my testimony is to share our opposition to CON's exception to the cities in Suburban hospitals and that are in the Detroit area. In an effort to reduce healthcare cost, Daimler Chrysler has been a strong advocate of Michigan's CON Legislation. We believe that CON has served Michigan well in terms of balancing affordability, acceptability and quality. We have seen tremendous cost savings in states where time has been inactive from Michigan, Delaware and New York versus states that currently do not have the necessary appropriate Legislation for us in Wisconsin and Indiana. It is our position that healthcare excess is related to affordability now that by geographic distances. Specifically the lack of health insurance coverage represents one of the biggest hurdles to excess healthcare services. The development for unnecessary hospitals, which I have helped the cause and started the excess to healthcare services. Healthcare cost for Daimler Chrysler in 2003 was $1.5 billion dollars. We employ 125,000 individuals, of which 41,000 are in Michigan. The number of healthcare contracts in Michigan is approximately 85,000. This represents our single highest fixed cost in producing a vehicle. Even more than the cost of steel. All of the automotive companies are living on very thin margins and have demanded cost reductions from respective and supplier communities to continue to do business in Michigan. To be a viable employer in Michigan you must work diligently to reduce the enormous inflationary increases in healthcare cost. The Unity proposal to develop a new hospital in Southeast Detroit appears to be duplicative since there is two hospitals within five miles for the residents of Southeast Detroit. Daimler Chrysler has many facilities located near the proposed hospital and approximately 8,000 active employees live in the city of Detroit. Although Daimler Chrysler provides significant health benefits to our employees, we understand the issues that a healthcare absence in Southeast Detroit. We apply to Samaritan Center for health needs and providing necessary comprehensive services to residents of Southeast Detroit. We also understand that Samaritan Center is pursuing the development of a new nursing home while steadily qualified primary health centers, and you would be able to least in the building. Daimler Chrysler has significant concerns regarding the creation of yet another hospital in this area. For example to establish not for profit an organization in the community of St. John, when able to maintain financial revival hospitals on the east side of Detroit. Trinity Health had to close for four weeks in Samaritan Hospital, at that time called Detroit Mercy. The Daimler Chrysler health system had to close the St. John Northeast community, Northeast hospital, formally Taylor Hospital. These organizations incurred millions of dollars and losses in efforts to maintain two hospitals. Exceptions to the standards for a hospital will increase the likelihood of major losses. We commend the Commission on its efforts to prevent the addition of these two new hospitals in Oakland County. There is no indication that the community needs these new hospitals. Service has suffered according to Dana, performed by Economic Alliance in 2002 and 2003 with a combined occupancy hospitals within a ten-mile radius of these two locations have less than a 48 percent occupancy rate. Daimler Chrysler believes that these new Suburban hospitals will not resolve financial problems facing the Detroit care systems. According to the local media, hospitals have estimated projected losses in Detroit in the amount of $200 million. A key underlining issue causing the Detroit Health System losses are higher proportions of Medicaid and other uninsured patients. This would not be resolved by building expanded urban hospitals. As stated in the CON application, the $20 million in profits generated by these new Suburban hospitals will not even come close to this loss figure of $200 million. Based on presentations today, there appears to be no demonstration of community need for any new hospitals in Southeast Detroit or Oakland County. If there wouldn't be a demonstration of community need, Daimler Chrysler wouldn't be adding Healthcare Services. However, since the CON Commission began to make an exception, the hospital beds, CON standards, without a significant demonstration of community need for a new Southeast Detroit hospital, there would be great pressure for other new hospitals elsewhere in Michigan. This would lead to even higher healthcare cost, with increased barriers to excess for the non-insured or under insured patient. Thank you for letting me provide this testimony.

CHAIRPERSON TURNER-BAILEY: Are there any other questions? (No response) Do you have a copy of your testimony that you would like to submit? We're going to break for lunch now. We're going to come back at 12:30. That's 35 minutes from now. At 12:30 we will reconvene. Thank you.

(Whereupon a recess was taken for lunch)

(Back on the record)

CHAIRPERSON TURNER-BAILEY: It's 12:35, it's a little later than we planned. We're going to presume with the public comment on Item Six, the Special Bed Allocation. Gerson Cooper.

GERSON COOPER: My name is Gerson Cooper and I'm the President and Chief Executive Officer of Botsford General Hospital in Farmington Hills, Michigan. I last presented testimony to the Commission a year and five days ago, regarding efforts to build unneeded new hospitals in Oakland County, and on the threats to the integrity of Michigan's CON statute. It is regrettable that a year later we're still confronted with this same issue. In January of this year, I celebrated my 45th anniversary with Botsford. In the days before the health planning acts expired, I was a provider representative and co-chaired the Statewide Health Coordinating Council. I am no stranger to health planning. Botsford is a 330-bed, independent community teaching hospital. We offer a broad array of general and specialty in-patient ambulatory services, and we have seen emergency department volumes fluctuating around 60,000 per year. A major teaching hospital in the osteopathic profession, affiliated with the Michigan State University College of Osteopathic medicine. We currently train 140 interns and residents in 17 specialty and sub specialty medical and surgical programs. We have worked diligently through the years to become integrated with the communities we serve, and have seen ample evidence that we are considered part of their infrastructure. Although our address is in Farmington Hills, we don't consider ourselves as exclusively a suburban hospital. Fully a third of our patients are Detroit residents. Our Medicaid volume of 12 and 14 percent qualifies us as a disproportionate share of hospitals. Our uninsured and under-insured patients result in extraordinary financial shortfalls. We face proportionately, the same challenges, as do the larger urban hospitals. The draft MDCH Addendum, Special Bed Allocation, added to your agenda for action today. Is based on the premise articulated in Section one---- to promote the continued liability of large, urban hospitals. This is a false premise. What will promote their liability is a continuation of the cost-reductions and systems improvements that both Henry Ford and St. John implemented that resulted in dramatic turn arounds last year, and you heard from Mr. Duggan. In 2003, the Henry Ford Health System increased unrestricted revenue by 170 million to almost $2.6 billion and generated an excess unusual items of $31.8 million positive. They were also able to add $100 million to long-term investments and other assets. In addition to Henry Ford Hospital in Detroit, they operate in-patient hospitals in Grosse Pointe, Wyandotte, Warren, Ferndale, West Bloomfield, and Mount Clemens in partnership with Trinity. Additionally, they operate 31 ambulatory medical centers throughout the Tri-County area. They are already in the Suburbs. According to Crain's Detroit Business, St. John posted a $14 million bottom line. The St. John website mentions that they have 20,000 employees, 3,200 physicians, 175 medical offices and 10 hospitals in six counties. They too, are already in the Suburbs. Providence Hospital, their Southfield, Oakland County affiliate, who has pursued an in-patient facility for their Novi Campus for some 14 years, operates 26 centers, offices and institutes in Southfield, Farmington Hills, Novi, Livonia, Brighton, Dearborn Heights, Northville, South Lyon and West Bloomfield-----none in Detroit. St. John Providence along with Genesys, Borgess and others in Michigan are all part of Ascension Health, the largest not-for-profit and largest Catholic Healthcare system in America. They reported $149.8 million income for 2003, and realized $799.9 million in net cash from operations. They achieved $9.1 billion in operating revenue; have $11 billion in total assets, and have total unrestricted cash and investments of $3.6 billion. The Internet, ladies and gentlemen, is a wonderful, wonderful tool. Consider, if you will, the impact of two new hospitals in Oakland County. To operate at a reasonable level of efficiency they will need to garner 32,500 admissions. A number far in excess of that expected to derive from market growth. While some of that volume would probably shift from Providence to Henry Ford hospitals, they will need to take patients from existing hospitals which are a valuable community resources providing necessary services. Trinity Health estimated last year that the re-direction of patients to new facilities would result in the reduction of $400 million in net revenues to the hospitals currently serving those same patients. At Botsford, the closest hospital to the proposed sites using driving time as a measure, we anticipate that we would experience the crippling effect of both a reduction in admissions and further deterioration in payer mix. And Botsford would not be the only casualty. Healthcare cost will increase. The two new hospitals will cost between $450 and $500 million. In their Notice of Intent, the Henry Ford Health System indicated a project cost of $272.5 million. And 90 percent of which will be debt-financed. That translates to an annual debt service of $16 million, or $195 per patient day if they operate at 75 percent occupancy. It has always been postulated that excess capacity drives up aggregate demand and creates over-utilization, and this too will increase costs of payers and consumers alike. Further, new hospitals will greatly exacerbate the already critical shortages in

nursing and certain other health professions. Competition for scarce human resources will increase labor costs across the entire region. We believe that there is not a need for additional hospitals in Western Oakland County, and the organizations that would benefit from this Special Bed Allocation have provided no evidence of unmet need. In 2002, those hospitals within a 10-mile radius of the proposed sites experienced average occupancy of about 50 percent. And can easily accommodate any anticipated market growth. Residents in Novi, West Bloomfield, and surrounding communities are currently well served by the extensive and sophisticated network of outpatient facilities operated by the proponents of the proposed hospitals. Both sites are within a 15 to 20 minute drive of existing in-patient facilities. These are not under-served communities. The Certificate of Need process benefited the citizens of Michigan. We ask that you not undermine the effectiveness of the program. The only action that should be taken today on this proposed Addendum is a referral to the Advisory Committee established for the purpose of reviewing and recommending action to this body. As the body charged with the responsibility of establishing standards, you need time to consider the impact this could have on the credibility and the effectiveness of the CON system. Thank you for this opportunity to address you and your attention.

CHAIRPERSON TURNER-BAILEY: Are there any questions? (No response) Patrick O'Donovan.

PATRICK O'DONOVAN: Good afternoon. My name is Patrick O'Donovan, and I'm the Director of Planning for Beaumont Hospitals. Thank you for the opportunity to provide comment on the proposed CON standards for hospital beds. It is unfortunate that these hospitals were not available for the public until yesterday. That notwithstanding, we believe the proposed standards are not in the best interest of Michigan residents, and we urge you to reject them on that basis. The C-1 statute requires the C-1 Commission developed CON, review standards that establish the need, if any, for health services in facilities that are covered under this CON program. The proposed revisions of the standards do not contain any element of need whatsoever. It simply award new hospitals without any consideration of the impact of those hospitals on cost, quality or access to health care services in this state. Make no mistake about it, the purpose of Section two of the proposed standards is to allow two new hospitals in Western Oakland County. When you look at Section two, the only conclusion that you can draw is that they were written in such a round about and confusing manner in an attempt to avoid conflict of interest problems because they need the votes to pass the language. It is the role of the Commission to develop and approve statewide CON standards. It is not the role of the Commission to pick winners and losers based on politics which the department is urging you to do. If these standards represent good public policy, then why were they developed in secret and trotted out at the last moment. Is it because they wouldn't stand the test of rationality? Let me address both the immediate concerns and the longer-term concerns about awarding hospitals without demonstrated need. In the near term, these standards would allow two new hospitals in Western Oakland County. Other than andicola evidence, no wonder data base evidence has been put forward to suggest that people who live in Western Oakland County don't have appropriate access to hospital care. I can see rates in hospitals in close proximity to the proposed new hospital sites are low. Note that hospital access is already part of the central charge of the recently appointed hospital beds Standard Advisory Committee. Beyond the access, proponents of the new hospitals say that they need access to a Suburban payer mix to subsidize their Detroit operations. However, consider that the sponsoring organization for the new hospitals already have access to over 1600 beds in Oakland and Macomb Counties and are operating those beds at about 60 percent accuracy. New hospitals are unlikely to generate $10 million in annual profit as claimed. In 2003, our Beaumont Troy hospital had a net income of $7.2 million, and all that bottom line was generated from outpatient care. We lost money on new-patient care. No evidence exist that new hospitals will be highly utilized. Even if the hospitals did generate the profit that they claimed. How many new hospitals in the Suburbs will be needed to offset $500 million in uncompensated care provided by Detroit hospitals. Unneeded hospitals in most of Oakland County that get build will have a negative impact on providers, business and labor and consumers in Michigan. Consider that the Capital require the buildings and hospitals will exceed $1.5 billion and these cost will be passed on to businesses, their employees, their customers and taxpayers. This is true despite the fact that Medicare pays fixed rates. Hospitals will negotiate with insurers, with other insurers, so that they can cover all of their cost, including depreciation. Existing hospitals currently serving Western Oakland County will clearly be hurt if unneeded hospitals are built in close proximity. One of these hospitals DMC Huron Valley hospital will be decimated because they are within 10 miles of both of these proposed hospital sites. You heard from Mr. Duggan earlier and Mr. Cooper from Botsford. Increased competition in the Suburbs for a limited number of health professionals will raise hospital cost and worsen staff shortages, thus adversely

affecting quality care. A proposed statute would require that the beds needed to create the new Suburban hospitals be transferred from other hospitals. Many of these hospitals will come from Detroit. Many of these beds will come from Detroit. Therefore, jobs and patients will leave the city. Members of the Detroit City Counsel recognized this and have testified in opposition to these standards. In the longer term and in a broader sense, awarding new hospitals without thoughtful planning, even once, will lead to the end of any credible CON program in Michigan. The result will be a proliferation of health facilities. Many of them for profit that will diminish the ability of non-profit hospitals to serve their communities. This is what happened in other states that have removed CON such as Ohio. Note that representative states introduced the bill and will allow Pontiac hospitals to establish new hospitals in Oakland County, even though these projects would not meet CON criteria. If this bill is passed, or if these proposed standards are passed, this will open the floodgates for more request for CON exemptions for a new hospital. In Section one, part of the rationale for the proposed standards is quote, "to address the critical problems of the 35 percent increase in Medicaid case loads within the last four years". We agreed that Medicaid is significantly under funded and this needs to be addressed by the Legislature. However, building new hospitals in the Suburbs is the wrong way to address hospital finances. The two proposed hospital sponsors, one to spend over half a billion in capital for hospitals that will generate at best $10 million per year, and that generation of income won't even start for a number of years. The Medicaid crisis is now. Does that make sense? By the way these new hospitals will destroy another hospital because existing profits are used to subsidize indigent care in Detroit. Where is the net gain in that? If the new Suburban hospitals are built because of increases in Medicaid caseloads, will these hospitals be closed when the Medicaid caseload goes down again? Which is projected to happen. Beaumont supports this strong CON program that applies to all hospitals in the state. Studies show that CON is associated with lower cost and higher quality. These standards, if approved, will represent bad public policy, and would worsen the problems that they purport to solve and may well lead to the end of the CON in Michigan. New hospitals should be authorized only after a rational data driven analysis show the need for such hospitals. Since these proposed standards were not developed on need criteria, they should be rejected. Thank you.

CHAIRPERSON TURNER-BAILEY: Are there any questions? Commissioner Sandler.

COMMISSIONER SANDLER: I have a number of comments about your testimony. Mr. Duggan expressed the need, expressed the concern based on one person telling him that. That it's not the wave of the future. Beaumont has added that significantly in the recent comments. Under the high occupancy standards, in which this Commission has passed. Within the CON process?

PATRICK O'DONOVAN: Correct.

COMMISSIONER SANDLER: What is your comment on that, and the fact intentionally in the near future, Beaumont may be back here or maybe submitting a CON to the department for having addition beds?

PATRICK O'DONOVAN: I would say that the additional beds that Beaumont got were based on criteria that was developed by an Ad Hoc.------

COMMISSIONER SANDLER: We both agree that Beaumont went through the process. That's not the point that I'm making.

PATRICK O'DONOVAN: And we demonstrated that there was a need at that facility based on existing occupancy rates at the facility, so we based that----------

COMMISSIONER SANDLER: I agree with that, but the question is when do you think you're going to be down the line having had these new beds? I mean Mr. Duggan's point was down the line you would need less hospital beds.

PATRICK O'DONOVAN: I don't know if that's true or not.

COMMISSIONER SANDLER: So, it may not be true?

PATRICK O'DONOVAN: It may or may not.

COMMISSIONER SANDLER: The City Counsel, you mentioned the City Counsel opposes this. Well, we did have one member of the City Counsel here. However, I do want to remind you for the record, not in terms of West Bloomfield and Novi, but in terms of Unity Health, there was a letter signed by all nine City Counsel members expressing their support for the Unity Health proposal.

PATRICK O'DONOVAN: I was referring to the relationships with Western Oakland County.

COMMISSIONER SANDLER: I just wanted to clarify that.

PATRICK O'DONOVAN: I apologize.

CHAIRPERSON TURNER-BAILEY: Any other questions? (No response) Thank you. Robert Asmussen.

ROBERT ASMUSSEN: Good afternoon. I'm Robert Asmussen, Vice President for Strategic Planning for St. John Health. What I'd like to do is limit my remarks to Section two, and some points of clarification with regards to Mr. Duggan's comments about comparative criteria. First and foremost, St. John's Health remains committed to exercising its rights under Public Acts 619, should that day ever ago given the unbelievable battles surrounding Public Act 619, and what appears to be an interminable delay in that process. So we appreciate the fact that the department has tried to create a standard that would allow us through St. John Health to meet excess requirements of our customer phase and the payer mix issues that are described in the preamble to the Standard. With regard to Section two, I think there are a number of points that need to be made. One is, no new licensed beds. People who testify always talk about cost increase, capacity, and we're not talking about new licensed beds, we're talking about the transfer of existing licensed beds to other locations. Number two, in contrast to previous standard development on this issue, we have introduced the comparative review process that relates specifically to Medicaid on compensated care, and for many of the Plaintiffs in the lawsuits and many of the people that you've heard from before or will hear from today, as well as people you've already heard from today, the comparative review in previous testimony from them was an important component of the standard. So this particular standard introduces the comparative review process. The third point that I'll make is that it does provide St. John, and there's no if, ands or buts about it, we are an applicant, a potential applicant for beds under this standard. To move existing licensed beds from our portfolio of bed assets within St. John Health to Novi. So that we can satisfy the excess requirements of that community and surrounding communities in that service area. Now, with regard tot he comparative review criteria themselves. If you listened to Mr. Duggan, and he was the only one to speak to the issue, you would be less than satisfied with what the department has developed as comparative review criteria. But, in fact, it does respond to the preamble of the standard. Specifically as it relates to the Medicaid percentages. The standard talks about Medicaid percentages in the county. Medicaid percentages in the city, as proxies for your availability to serve that population, and your actual Medicaid percentages. He thought it was unfair to take away points, if you will, receiving direct grants for service to that population. We're reminded, Commission, that the only organization that received dollars this year, special dollars, was the DMC to the tune of $50 million. I'm not aware if Ford received any dollars, and I'm certainly aware of the fact that St. John Health received no dollars. He also complained about the fact that you're scored fewer points under disproportionate share payments. Well there are $45 million allocated to this disproportionate share pool in this state. The DMC received $33 million of the $45 million to the state. So, for the department to say that you get high points for those you serve and the potential to serve and you get fewer points if you have excess to dollars to support your ability to serve the Medicaid population, then our judgment on those are valid criteria and points provided to various comparative review criteria. So, none of us have a lot of time to look at these proposed standards, but certainly in the short period that we have had, we would certainly endorse the Commission sending out this draft for public comment. Ourselves have questions, concerns and I think everybody has the ability to write different words, and we would certainly like that opportunity if the time were provided us to provide that during public comment. So, again our position would be that the Commission has developed a very difficult arena, a standard that deserves review to the public comment process, and then your considered review after that fact. Thank you. If there are any questions, then I'll be happy to answer them.

COMMISSIONER MAITLAND: On your last sentence, you said the Commission developed and I don't

believe the Commission developed that.

ROBERT ASMUSSEN: I'm sorry.

CHAIRPERSON TURNER-BAILEY: Any questions or comments? (No response) Mike Slubowski.

MICHAEL SLUBOWSKI: Chairperson Turner-Bailey and members of the CON Commission, I thank you for this opportunity to appear before you today. My name is Michael Slubowski. I am Executive Vice President of Trinity Health's Eastern Division. I'm testifying today to ask you to reject the Special Bed Allocation language that is on your agenda for consideration. Pages one and two of our briefing Summary, which was handed to you today. It will remind you of some elements of our previous testimony on May 28th and June 10th of 2003 regarding PA 619 and other initiatives to establish new suburban hospitals. The briefing Summary includes hard facts on financial viability, service areas, and need. To summarize our position, building new suburban hospitals would not solve the Detroit hospital's financial crisis. The facts that we present in this document on pages seven and eight demonstrate that these new hospitals would generally insubstantial income and will not provide a return on investment to offset uncompensated care losses. It has been pointed out that, from review of actual statistics, the growth in population and changes in use rates do not appear to be substantial enough to make the case that these new Suburban hospitals can succeed without taking business from other Suburban providers. Furthermore, the drop in volume and income at existing hospitals will put their charitable missions at risk. Building new hospitals will weaken many existing Suburban hospitals, including safety net hospitals in Pontiac. The Detroit Medical Center has recently made its concerns known about the adverse impact of these hospitals on their Huron Valley Sinai hospital and the subsequent adverse impact on their Detroit operations. The passage of Special Bed Allocation language violates all the principles of establishing bed standards and approving new hospitals based on need. This would require a thoughtful and quantitative planning process that balances cost, quality, and access, and considers bed need based on population and demographics, use rates, drive times, and other important factors Who has provided solid, documented evidence of need to this Commission that would result in this arbitrary Special Bed Allocation? The passage of special language to exempt Henry Ford and St. John from obtaining a CON for construction of new Suburban hospitals without documentation of need is wrong for the community and disregards all principles of planning. If this language is passed, the CON process will be greatly diminished, possibly leading to the end of CON as we know it. It will be the most significant opening of Pandora's Box to date. There will be a proliferation of "end runs" around the CON process by other providers, because all it will take is enough lobbyists and lawyers to make it happen. Last summer, draft language was introduced as proposed modification of the CON standards. This draft language literally lifted special exception language for new hospitals for three providers from PA 619 and inserted it into the CON standards. Rather than updating the bed need methodology and having hospitals follow the CON application process for beds, it literally gave a "no bid" contract to three providers without the accountability that CON was designed to accomplish for public good. Today's proposed Special Bed Allocation language is a cleverly written way of creating loopholes for only three providers that accomplishes the same end run. We cannot support these proposed changes to the CON standards. Finally, given the proposed Special Bed Allocation language for another purpose, Trinity Health has been asked to state its position regarding the proposed project by Unity Health to operate a 200-bed hospital at the Samaritan Center, which is the site of the former Mercy Hospital-Detroit. Ms. Donna Littlejohn, Administrator of our Mercy Primary Care Center in Detroit, testified twice before you on this subject. Our position is quite simply to reiterate three points: First, Trinity Health believes that there are better uses for the building that it donated to the Samaritan Center other than a hospital- uses that were planned in coordination with the local community and many social service agencies when the building was donated in the year of 2000, and many of which are tenants of the building today. Second, Trinity Health does not believe that a hospital is sustainable at that location. Third, the building now belongs to the Samaritan Center's new owners. As the owner, the Samaritan Center is free to do with the building as it pleases, provided that its uses do not impair the tax-exempt debt on the building that Trinity Health is still paying. In summary, CON standards and the CON process are designed to look at Need. This requires a thoughtful and quantitative planning process which balances cost, quality, and access, and considers bed need based on population and demographics, use rates, drive times, and other important factors. We do not believe that any of the Special Bed Allocation language that is proposed takes these principles or any hard data into account. The numbers just don't add up. We ask that you reject the Special Bed Allocation language that is proposed today. Thank you.

CHAIRPERSON TURNER-BAILEY: Are there any questions?

COMMISSIONER SANDLER: Yes, I have a few questions. This goes more towards Mr. Donovan's testimony. The question is CON's lower cost, well as again, no peer view published material that substantiates position. I would reiterate to follow it, but those of us who wish to have CON continue, I would suggest that this information of methodology be published because it would give it a great deal of support to CON. As far as increasing quality goes, as a physician it would be pretty intuitive that the buyer requirements would increase following the end. It would be significant reason to have a CON process. So, CON does get a good boost on the quality issue, and there is some evidence that would suggest that we could buy you for Cardiovascular surgery for example. So, that actually has been public in terms of outcomes of volume. I would suggest that if anyone has material in this room that can confirm the lower cost, I would like to see it published because that would give significant impetus to this planning process that would justify as the attributable. The two groups said it was about a wash when they investigated, and that's only one person's opinion. My comment was actually, well, whether this was passed or not, I don't think it's going to be the end of CON as long as Jennifer Granholm is the Governor. But as far as clarification about the unity, it was my understanding of the following: If this is incorrect, I would like to be corrected. It's a matter of opinion. But my understanding is that the purpose of a CON Commission was to simply pass or not pass a standard that would allow that to happen. Not to become involved as the Assistant Attorney General told us about comments about when is the appropriate tenant mix in a particular building; isn't that correct?

RON STYKA: Yes.

COMMISSIONER SANDLER: So, even though and I commend Ms. Littlejohn for all the work she's done in that area of Detroit, but that itself is not a topic in which the Commission gets into. We have some very intelligent people in the city, and they are to reject the CON of Unity Health or whoever that doesn't fulfill the criteria which is settled. They may object to the Trinity Health, they may not have the appropriate space. But that is nothing to do with setting the standard of the Assistant Attorney General's office.

RON STYKA: Is that a question?

COMMISSIONER SANDLER: A statement. But if you wish to comment on the statement, please do so.

RON STYKA: No, I made my statement.

CHAIRPERSON TURNER-BAILEY: Are there any other questions?

COMMISSIONER GOLDMAN: Yes, two questions. First, did you intentionally mean to put lawyers and lobbyists in the same sentence?

COMMISSIONER SANDLER: Yes.

COMMISSIONER GOLDMAN: Second, on the material you gave us, the time and travel map for Novi and West Bloomfield in the existing hospitals, what is your understanding of where these two potential new hospitals will be located and what their access to be versus the one you showed us?

UNIDENTIFIED PERSON IN THE AUDIENCE: The two general hospitals proposed in the CON that was submitted for Providence Park Novi.

COMMISSIONER GOLDMAN: What comment, if any, do you about those two points given in your map and the given the questions that was raised about need and access?

MICHAEL SLUBOWSKI: We don't believe there is any based on that map. The points that have been raised and the arguments work with the hospitals.

COMMISSIONER GOLDMAN: Because you think that St. John, Botsford, Providence and other hospitals

that you have on the map have adequate criteria?

MICHAEL SLUBOWSKI: Yes.

CHAIRPERSON TURNER-BAILEY: Any other questions?

COMMISSIONER SANDLER: Yes, I have a question. The Legislative bill doesn't name a particular people. There is certainly speculation that this refers to Pontiac Osteopathic hospital moving to Clarkston. However, I want to make it clear and I don't want anybody angry at me, but it doesn't specifically give those names. That would be speculation. You stated and I understand that it's not a Legislative issue, correct, Mike?

MICHAEL SLUBOWSKI: I didn't comment on the move at all in my testimony.

COMMISSIONER SANDLER: You commented on a bill on the Legislature. Was that not the bill you were talking about?

MICHAEL SLUBOWSKI: No.

COMMISSIONER SANDLER: Okay, I apologize, I thought that was the bill. I want to withdraw my question.

CHAIRPERSON TURNER-BAILEY: Are there any other questions or comments?

COMMISSIONER MAITLAND: Dr. Sandler mentioned the intelligent people on the left, but we on the right also think we're intelligent. I just wanted to put that on the record.

COMMISSIONER SANDLER: That, I assume, means left to right politically.

CHAIRPERSON TURNER-BAILEY: James Ball.

JAMES BALL: Thank you, Chairperson Bailey. I apologize, my name is James Ball, and I'm the Assistant Director of Healthcare Planning for General Motors. I previously served as the Chair of the Hospital Bed Ad Hoc and currently serve on the state's seat. I apologize for not having prepared comments today, and perhaps I'm wondering a bit, but I just received this material last night and I didn't have an opportunity to review it in depth. I think the Certificate of Need Commission is Impiously named. The Commission on cost that the Certificate on payment source. It could have been the Commission on COD, and that would be the Certificate of Desires, or it might have even been the Commission of Cope, and that would be the Certificate of Political Expediency and it's not. It's a Commission that's supposed to deal with need as several people have mentioned. The need is often in the eye of the beholder. Probably all of this are parents or marital partners dealing with a budget, that dealt with kids that said they absolutely needed something, or a spouse who said we absolutely need this at the house. It does, as several people require, said it required close analysis, not a quick response or conclusion with regard to need. Now, the department, Jan will probably be surprised to hear me say this, but in our previous deliberations I think the department had commented on what we did with regard to the numerical calculations and the service areas and so forth, was incomplete and there was other aspects that dealt with need and access and so forth. So, there was talk of various social economic consideration and so forth, but what you have before you today seems to put all of the emphasis on only one point, and it's a significant point. The issue of Medicaid and compensated care. There are certainly many others. I think you may recall that Mr. Zwarensteyn submitted quite a list of social economic issues that he thought ought to be addressed in the future when we did our prior work. None of those seemed to be considered here. There's questions of if new hospitals were open, then you'd read about a competition for nursing capacity and adequate supply of nurses and adequate supply of certain technicians and so forth. If you have new capacity and bright new facilities, one wonders where the nurses go and where the technicians go. Do they go to those nice new facilities in the Suburbs and abandon the facilities in the city and what's the impact on excess then. What's the impact on quality care in the inner city and so forth. We heard comments this morning on general applicability, and I'm not sure if the standards before you would be broad, general applicability. They seem to be structured

to deal with two or three hospitals in particular. I don't recall off hand what combined metropolitan statistical areas are, how many of them there are. I suspected the euphemism that somehow identifies the very tight area so that it would limit the applicability of the standards. You heard on the Unity proposal, you heard a number of things that people said that we need a new hospital because, and they talked about servicing the uninsured and the under-insured population. But as Mr. Duggan commented on, they don't have any immediate plans to have an emergency room nor do they plan to do maternity care. Those are the two big needs of that population, but they plan to sort of shift those over to the other institutions and just take the compensated care. You heard them talk about lack of access to transport. Well, I don't know, my company deals in the transportation business. I suspect we could provide a lot of vehicles to move people to the hospitals they need to get to with significantly lower expense than building new hospitals. I don't think lack of transportation is a good reason for building a new hospital. Particularly one within a matter of five miles, you have hospitals that are already operating on global low capacity. You heard them talk about physicians wanting another hospital in order to have admitting privileges. And one wonders why is it necessary to create a new hospital to have admitting privileges. Should we be looking at the question of what are the standards for admitting privileges that keep those physicians from admitting privileges at hospitals or should somebody be looking at why the physicians don't have admitting privileges. We talked about access to specialized equipment. Much of that specialized equipment is subject to other CON standards. If there's need for CatScans and MRI's and CT's and so forth, make the case for it but don't try to turn it into a case for building a hospital. All of these items, I think, are aspects that should properly be dealt with in the SAC. I was surprised to hear the comment from Mr. Christensen, that the SAC, and he suggested, that it's dealing only with the geographic issue, and my understanding of the charge it speaks to excess and the relocation of hospitals and so forth went to a broader term of excess beyond just geographic arguments and I thought the charge was, in fact, a response to the issues that have been raised before, that excess did bring in a lot of these other areas, and that's what the fact was supposed to deal with. I would have liked to have seen these suggestions or recommendations come to the SAC. There was this meeting that was scheduled and wasn't held, but I think that was the appropriate place for these to go and I would support the motion by Commissioner Maitland to move this issue to the SAC because I think that's the appropriate place to deal with this. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions? Yes, Mr. Christensen.

JAN CHRISTENSEN: Just a point of clarification in response to the question or the applied question of what a combined metropolitan statistical is. There are four in the state that comprise 21 on the counties. The clusters are urban counties with certain populations. I would also attempt to correct that the language of creating new hospitals adding additional capacity, and it is not with this proposed standard. It doesn't add one new bed to the statewide inventory. That is the principle. I would also like to put another comment out there. There's nothing in the new standard that implies that we should be in the business of creating monopolies to create beds. Including these hospitals that provide services throughout the state.

COMMISSIONER DEREMO: JAN CHRISTENSEN, could you state what the four combined metropolitan statistical areas are for our clarification?

JAN CHRISTENSEN: Yes, I can. There would be Detroit, Warren, Flint, which includes the counties. That includes the county of Washtenaw and Lapeer and Macomb, Oakland, St. Clair and Wayne. There is Grand Rapids and Muskegon and the city of Howell, and that includes the counties of Allegan, Ionia, Kent, Ottawa, Muskegon, Newaygo. There's a Lansing, East Lansing, Owosso that includes this language, that includes Clinton, Eaton, Ingham and Shiawassee. There's a Saginaw, Bay City, Saginaw Township North CSH that includes the counties of Saginaw and Bay, with a total of 20.

COMMISSIONER DEREMO: Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you. Any further questions? James Falahee.

JAMES FALAHEE: Thank you, Madame Chairperson. I like, Mr. Ball, in the interest of full disclosure, a former member of the hospital bed Ad Hoc. Take that as you will. A current member of the SAC. Mr. Goldman, I too am a lawyer and worse I'm a lobbyist agent. So, take that all together. I would like to point out one thing. Unlike the other speakers that you heard from today, I'm not from Detroit, I'm from

Kalamazoo. I see Mr. Christensen has left, but I guess on what you said, I'm not a combined MSA, so I don't count. The people in Kalamazoo County. The people in county of Battle Creek, the people in Benton Harper, they don't count. They are taken under these standards. We are not a combined MSA. I think that's part of the problem with this issue in front of us. I would strongly urge Mr. Maitland's motion to be adopted because what we have here is a standard that literally came out in the 11th hour. I was out of the office yesterday. I checked the e-mail about 10:00 at night. That's when I found the three e-mails from the CON department because there were transmission errors. I got to the third one and I got this standard. So, I read the last one and I couldn't quite believe what I read, so I got up this morning about 6:30 and read it again and said this doesn't make sense. I've been working on the CON's process since my first CON in 1981 or 1982. This is bad policy, just bad process. I'm not here to talk in favor of or against the language, I'm talking about the process itself, and that's why we encourage the motion that's on the floor to be proof. Why do I say that? Not only do we have the 11th hour issue on this, we've had no constructive discussion whatsoever. When you talk about sending a proposal comment, I don't know how many of you have been to public comment sections, they're not public comment. It's open-mike editorial opinions with no interchange back and forth. There's no dialogue back and forth. You sit and you talk through a mike and you sit down. That's it. That's not a public comment. That's not how this Commission or any Commission should work. You need to interchange ideas back and forth. Also to exclude certain areas of the state, I think it shows that you got, for example, in Southwest Michigan is not a combined MSA. Does that make this language with others called generally applicable? I don't get that. Also the standards, I think, are unclear. In my initial look at it, I agree with some of the comments that the prior speakers have made. I also would like to add that what this provision for emergency department mean? Does that provision mean that we'll have one open day one, 24/7/365? Does it mean we'll let the other hospital within five miles away do it? I don't know what that means. The department that serves here is a Commission and there's a puzzle to access to care, and we need to look at those issues. The 2.5 percent number. The question was asked of how we got to the 2.5 percent number of beds. I don't have an adequate answer to that yet. Did we back into the number or was there a rational basis to get to the number, I don't understand that. Finally I think what we have here is an 11th hour decision for a proposed standard. Years and years ago before the CON was around thankfully, someone said you don't want to see two things being made; the laws of sausage. I think I know why. I think if we want to have a law, policy or standard that addresses the interest of this population in the state of Michigan of where we're headed, we need to send it to the strategic Advisory Committee. I'm not saying that because I'm on that committee, I'm saying that because we shouldn't just have a decision on something that was enacted or approved or issued yesterday. We should have a full discussion on it within the Standard Advisory Committee so that if we go there, we'll have a broad charge to that committee that charge that encompasses as you created the Standard Advisory Committee. There are qualified people there. We're not potted plants sitting around the tables. Let us liberate, let us look at these issues. So, I would encourage you to approve Mr. Maitland's motion. Send it to the SAC so that we can have a full deliberate and intellectual discussion on these issues. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions? (No response) As a reminder to all speakers, would you please sign your name on the ledger as you come up to speak. We'll also need for you to state your name and your organization for the record. If you spoke earlier and you forgot to sign, please return and do so. Representative Artina Tinsley-Hardman.

ARTINA TINSLEY-HARDMAN: Good afternoon. I'm Representative Artina Tinsley-Hardman and I serve the Third House District of which 5555 Conner is right there in my district. I first would like to read a letter on behalf of Reverend Joseph Jordan, who is a very important part of our community. He is the president of the Council of Baptist Pastors of Detroit Vicinity, Incorporated. "Dear Chairperson Turner-Bailey and Honorable Members of the Commission. I am addressing you today on behalf of he Council of Baptist Pastors----Detroit Vicinity, to request your support of the proposal before you to provide beds for the proposed Unity hospital. The Council and I hope that this letter finds all of you and your families in the best of health. The Council has spent considerable time addressing and investigating the crisis of health care in our communities. Hospitals in and around the city have closed or eliminated the delivery of health care services over the last five years. This drastic reduction of health care providers places our communities and especially our children and the elderly, in particular peril. We know that you have been entrusted with the awesome responsibility to determine how to address the need for health care. The entire body of the Council together with its Executive Board and I, have endorsed the plan by Unity Health, L.L.C. to return a hospital to the East Side of Detroit. This is based upon our conclusion that more hospitals are needed

throughout the city of Detroit. The health care systems, such as Henry Ford Health, St. John Health, and Detroit Medical Center, continue the delivery of health care services in the city, despite economic forces which may have worked against their efforts. We applaud their commitment to Detroit, while they continue their efforts to serve other communities as well. It is clear, however, that the future of health care in the city of Detroit will best be served by returning the community hospitals to its neighborhoods, so that physicians can maintain practices close to their patients. Many in our congregations face great obstacles in reaching hospitals in time. True access to health care must be measured in more than mere distance. True access must ensure that each person has access to hospital beds, if necessary for their care. With a population of approximately 360,000, the east side of Detroit is in need of additional hospitals. The emergency room waiting areas are over-crowded, with many waiting 12 hours or more before a bed may be made available. Although outpatient facilities are needed, a hospital is essential to the survival of these individuals, most of whom are children and senior citizens. This crisis requires immediate attention. The Council supports the concept and plan to return hospitals to the City of Detroit, and it opposes anyone who intends to stand in the way of those hospitals. Such opposition could only be for selfish goals which have nothing to do with caring for the sick and infirm. You cannot see the state of health care in the city of Detroit on a daily basis, as do we Pastors, and still oppose the opening of more hospitals. We respectfully ask the Certificate of Need Commissioners each consider the desperate circumstances facing the people of the city of Detroit, and particularly those on the east side. No other projects have been proposed for those communities which will replace hospital beds. The members of Unity Health have endeavored to return a hospital to the east side of Detroit. This group of African-American physicians and business persons must be given the same opportunities to provide hospital services to their communities are being afforded to the suburbs. The Council of Baptist Pastors----Detroit and Vicinity, and I, strongly urge you to provide our city with the means of caring for itself. We truly appreciate the efforts of each of the Commissioners to respond to the health care needs of the citizens of the State of Michigan. We hope that, as you search your souls for the correct path upon which to place health care, you will support and approve a proposal which will enable Unity Health to obtain hospital beds. A united community working together will enable us to save lives which otherwise may be forgotten. Sincerely Joseph R. Jordan. He is the president of the Council of the Baptist Pastors in the Detroit Vicinity. I salute Reverend Jordan, but now you are going to hear from me. I'm not just a state representative, but a person who has lived in that area all of my life. A person who was there when the Samaritan Mercy hospital opened up some years ago because of the need in that community. There was so many people suffering from Cirrhosis of the Liver. I stand before you and ask you that you please consider giving Unity an opportunity to open up these beds. There is a critical shortage on the east side in terms of beds. I don't think there's anyone else who came before you opposing this, who lives in that community. I live in that community. My family lives in that community. My friends live in that community. I believe we should have the same opportunities that other people have. We have people all around this state, in fact, there's a hospital not far away that tried to open up some beds, and I understand that they were in the process of being served in some kind of way. We have got to stand for what Michigan needs. We have to make sure the process is safe for everybody. I do not see that happening here. I won't be satisfied until it happens. There's a Governor that talked about creating one Michigan. We have to make sure that when we're talking about creating one Michigan, that everybody is included in the process. This should not be about dollars. This is about people's lives. People on the east side of Detroit who deserve to have this facility reopened again. It was built to be a hospital. It was built to be a hospital. In fact, before they closed it they put $23 million worth of reconstruction into that building. It's a good building. I was there just recently. So, I would encourage you, I implore you, I ask you to please consider making sure that the people on the east side of Detroit are covered with healthcare. I think that if they, as a community, want to see Unity opened up, then we deserve that. We deserve to have that happen. And to the gentleman who spoke from Attorney General's office, who said give him a car. Let's give him a job to go along with that car, and he can get his own car. Thank you.

CHAIRPERSON TURNER-BAILEY: Any questions? Commissioner Goldman.

COMMISSIONER GOLDMAN: You had indicated that you were recently in the Samaritan building. Can you comment about the services currently being provided at that building?

ARTINA TINSLEY-HARDMAN: In that current building you can get your hair done. There are several programs that are currently in that building. Some of them are good programs. I think with Unity coming, Unity has agreed to work with these programs. They think they can make it better than what it is because it

can be better. That's what a community is all about, working together.

COMMISSIONER GOLDMAN: You indicated and Reverend Jordan in his letter indicates that the Council supports plans to return hospitals to the city of Detroit. Do you have any comment on hospitals in the city of Detroit that is run and raised which you would lead beds to the Suburbs?

ARTINA TINSLEY-HARDMAN: My only comment to that question is that the people in the city of Detroit, we have access to adequate healthcare. I think it is a problem when people want to leave the city or to take beds out of the city. What happens then to those people. We see that a lot. I see it a request for it all the time. There was one last week for Pontiac to move to an advanced, to Clarkston. It happens a lot. Pontiac is another urban area where people want to fly away. The people in Pontiac and in Detroit and all these other urban areas deserve access to good quality healthcare, and I believe that Dr. Jordan in his letter was very specific. He believes that Unity, L.L.C. would be the hospital of choice for Detroit.

COMMISSIONER GOLDMAN: I guess the question that I'm asking is if Community Health were to open in the Samaritan building, where as this proposed standard hasn't previously licensed healthcare facility building. Would that satisfy the need or would that plus the facility also available in that building, plus facilities in other hospitals be necessary? I'm not sure of what you're telling us. Are you telling us that there are 200 beds that Unity opens or Samaritan or a facility like that. That would take care of the need in your area?

ARTINA TINSLEY-HARDMAN: Absolutely. That would definitely take care of a big need. It would take a burden out of some of these hospitals in that area. This is supposing that they have been bombarded. One of my colleagues says that his mother was walking through Walmart and a box fell down and she got hit in the head. They took her over to St. John's, but they had to turn right around because they were full. This hospital is open but they didn't have a bed. It's a problem.

COMMISSIONER GOLDMAN: If the hospital had been open and at the time of opening, there was a fully functional emergency room, is that your need? I'm not trying to put words in your mouth. If the need is for a fully functional emergency room plus some beds, should somebody go to the emergency room that need hospitalization, then I would as a Commissioner, want to see both of those things happen at the same time, but I'm just trying to find out what your position is on that.

ARTINA TINSLEY-HARDMAN: My position is that the hospital that's being proposed to open at the 5555 Conner site would be an in-patient hospital where emergency care could follow.

COMMISSIONER GOLDMAN: So, the example that you just gave us, you're a family member or friend, would you have to still go to St. Johns or Henry Ford, because they would need an emergency room. Is that right?

ARTINA TINSLEY-HARDMAN: No.

COMMISSIONER GOLDMAN: There wouldn't be an emergency room at this facility on day one.

ARTINA TINSLEY-HARDMAN: Not on day one, but as the process follows, they're looking towards doing that.

COMMISSIONER GOLDMAN: As a representative, what would you want our policy position to be in order to serve this population? One policy position is a hospital with a fully functional emergency room on the day that it opens. Another is a hospital dependent on emergency rooms elsewhere. Do you see what I'm asking you. If you are saying that there is an unmet need, and if part of that unmet need is an emergency room, then wouldn't a better public policy be a facility that had initially both an emergency room and some new patient beds?

ARTINA TINSLEY-HARDMAN: I guess you can answer that in two kinds of ways. I haven't read the documents in terms what Unity is supposed to do with that. I support that in terms of what they are trying

to do with that facility. It would be a great thing if both had opened at the same time. However, I think they should still be allowed the opportunity to open up another hospital that would serve in that community.

COMMISSIONER GOLDMAN: You don't think it was an acceptable public policy to have the beds first and the emergency room to follow at some specified time, some unspecified time. How would you do it?

ARTINA TINSLEY-HARDMAN: I think it would be great to have a facility with an emergency room and also beds at a specified time.

COMMISSIONER GOLDMAN: Like when the beds open?

ARTINA TINSLEY-HARDMAN: When the beds open, if that were possible.

COMMISSIONER GOLDMAN: Thank you.

CHAIRPERSON TURNER-BAILEY: Any other questions? Thank you. Richard Smith.

RICHARD SMITH: Good morning. My name is Dr. Richard Smith. I am a native of Michigan. My grandfather's grandfather was born in Michigan. I'm concerned about what's happening with health care in the city. I'm an Obstetrician/ Gynecologist and delivered almost over 6,000 babies. I guess we talked a little bit about OB earlier. I'm also the President of the Wayne County Medical Society, which represents 5,000 doctors who practice in this county. I'm also the Chairman of the Board of Governors. A physician group at Henry Ford hospital. Eight hundred physicians and physician scientists and researchers who represent the Henry Ford Medical group. I'm the chair of that body. I can say that's my day job, but my night job is an Obstetrician, so last week I delivered a lot of babies and I've taken care of patients in the city; people who come from, just last week, from Israel, from Mexico, from Macomb County, from Western Wayne County, from Grand Rapids, and Brighton and the Detroit area. That's what urban medicine is. You take care of people from all walks of life and from different backgrounds. As I mentioned I do deliver babies, but I also in my clinic, I also this week took care of a woman who was 60 years old, who was at the GYN clinic because she didn't have a primary care doctor. When you look at her, this woman was 60 years old and haven't had a mammorgrams, haven't had her colon regular assessment , hasn't had a cholesterol check because there's no doctors in Detroit anymore. They haven't been able to maintain a practice. You may see a woman who is in her 70's who comes to you because her doctor has closed up shop and has left. That's the issue we're talking about when we say "access of care". That if we weren't there, then that woman would show up in some emergency room somewhere when she began having chest pains. That is what is going on in the everyday life of the citizens who are in the city of Detroit. I am here today to ask you to support the new CON standard. One that will allow for the flexibility of Health Care Systems that serve urban markets that we talk about. Not only in Detroit but throughout Michigan. This is an issue of viability of our health care organizations that serve those in desperate need of care, those on Medicaid and the uninsured, but those who are often forgotten by most providers over time. We need you today to take action on the Certificate of Need standard that will allow the state of Michigan to respond to the special needs and circumstances of communities such as Detroit in a fair and equitable manner. We've all heard all kinds of numbers and statistics today, but it's worth repeating. More than 50 percent of Detroit's population is either uninsured or on Medicaid. With that significant percentage, there is no possible way for physicians or health systems to allocate or shift these cost. We must have other options to provide care in other venues or the few physicians that are left in Detroit or they'll leave. There's not one solution and we've been all over the board today with this. I'm hopeful that as we look for new ideas and new models, we can come up with something. The Wayne County Authority is an excellent example of all the systems cooperating. Something that was lodged a year ago by all the different parties involved and we have come together to work towards one applicable solution. I hope that will address some of the needs. Please know that most of the physicians and hospitals that serve the city of Detroit are doing many things to help low-income families and they are passionate about the continuing those initiatives. I'm passionate about it. I take care of a lot of teenagers and we've been doing so for over 25 years. We've also done special clinics and models to our system; Henry Ford Health System and St. John, for example, are currently working together to sponsor more than 20 school-based clinics. Henry Ford provides nearly a million dollars a year for this vital program to our school children. If we're not there, then those programs don't exist. Now, you've heard about school based programs, but we've taken our

philosophy to care, which is one of continued innovation, quality control and managing the cost and ideas and taking this into a school system with the idea of not just saying we have another system, but we look at middle schools for example, and we say why not take care of these kids before they become sexually active and get pregnant. To this day that clinic has been there almost ten years. We can say that there hasn't been a single teenage pregnancy in a high-risk area in this middle school group. That's quality care. That's what we bring to the table when we talk about opening a center. One of the other people talked about multiple clinics. We're totally an integrated system. We have a philosophy of care which is totally quality management and looking towards the future, because it's that type of management that will reduce your cost. It's not looking at old data and say "oh, you built a hospital, they'll come and drive up the health care cost". Quality management, a philosophy of that will actually reduce your cost. That's what we do when we integrate or bring another clinic on line. We bring another clinic on line in Detroit, right downtown in Detroit, another deviated area. We're opening up one in the Harbor Town area. We'll employ about 25 people there as well, who'll provide services to that area. We are committed to Detroit. We have facilities right in Hamtramck. We has CHASS which is on the west side of the city. Which is a large Hispanic community. It's one of our family-funded facilities care centers that we have, as well as ACCESS. Again, totally integrated with our electronic medical record system, which reduces cost. It does not drive up cost but provides care, a new model that we will bring to the table. This is the philosophy that we bring, so we're a little bit different then that. I've given you some ideas of what we're talking about. We talk about cost. There's a way to manage cost in spite of giving good quality care. The Physician's Group is committed to that. I've also brought you some letters from Mother Ingalls, who supports what we're trying to do. We'll distribute them as well. This new standard we're talking about will also address a key concern that our Michigan Department of Community Health has. That's the area of Minority Health. This is an area where the Surgeon General Dr. Kimberly Dawn Wisdom, has identified as a priority for the state of the Michigan. This particular one will be a tool that will help re-establish African American community hospitals and some of those will be replaced after being lost over the past 20 years. It's very important for recruiting more physicians in our area. You can truly make a positive difference of lots of many people throughout our state and by the Michigan Department of Community Health. This is a needed tool. You'll be supporting our urban areas, who are in desperate of viable options. I think what you need to do is really take action today and support the Certificate of Need standard. I'll end my comments here. Are there any questions?

COMMISSIONER SANDLER: One comment. I believe the letters that you're talking about, Dr. Smith, have been handed out already.

CHAIRPERSON TURNER-BAILEY: Are there any other questions? (No response) Thank you. Vinod Sahney.

VINOD SAHNEY Good afternoon, my name is Vinod Sahney, and I'm Senior Vice President of Henry Ford Health System. Given the time, I will be very brief and just talk about four or five key points. One, a number of people have said that this is something that has come up within the last few weeks or months. I just need to remind those Commissioners who have been on the Commission that two and a half years ago I testified here and said we are facing tremendous burden and problems in the city of Detroit because of increasing Medicaid and problems with the uninsured. So, this problem has been here for two and a half years. During that time we have applied every approach. There a number of different proposals in front, standards, I testified on June 10th of last year on the standard that was defeated. September, October, January and February meetings, and this is nothing new. I just want to remind you that I am not asking that you approve this. All we are really asking is that it's time that you take some language from public comment. Move it forward one step. Receive public comment, and you still have two months until September to figure out whether these are the right standards or not to approve. So this process right now is to really move this one more step into the process. Otherwise you be here in September and then some language will come up and I am sure the gentleman who spoke before me and a few of them will again come up and say I was on vacation and I just got back two weeks ago and I didn't get a chance to look at it. It's a lot of frustration on this. Let me comment on a number of different issues that have been brought up. Our single biggest issue that I came two and a half years ago was access in the city of Detroit. This standard addresses the access in the city of Detroit in two ways. One, is the Unity proposal, and the proposal standard that has been in Section three of this current proposal addresses an issue towards this position that is out of the population shared and pyramid share in the city of Detroit. The issue is access to

primary care, lost of more than 25 community hospitals. Many of them that have been closed for the past 15 or 20 years. It's very easy for a system that has closed hospitals in the city and moved to the Suburbs to come here and say that having a Suburban hospital won't support the city's problems. Well, there has to be some other alternative now. It is not sufficient to constantly point to something that won't work and somebody else should be solving the problem. This is a very concrete proposal that is being put forward. About Henry Ford hospital, others have said, "well, if this is approved, Henry Ford hospital will not be serving the residents of the city of Detroit. Not true. Since 1915 we have demonstrated a commitment to stay in the city when many others have closed and moved out. Our flagship is in the city of Detroit. We continue to invest capital. We have just authorized in the current budget, $75 million in the city of Detroit for expenditures. These address two items; expansion of the emergency room, which is being flooded by patients who are coming in, over 100,000 visits to the emergency room in the city of Detroit, and this brings up the issue of beds. This is an issue that I think Commissioner Hagenow brought up that we need to do, and we are working on that. Many of the beds in the Detroit campus are over 60 years old and we are renovating them so that we can provide care. I just need to share with you our financial statement of 2003. Last year we provided, in 2003, uncompensated care, another increase of 15 percent, $110 million dollars based on reimbursement and not based on mere charges. $110 million of uncompensated care. So, we keep working on that and we keep coming back to you and we ask for some help from you. Now, a number of people have pointed out, including my friend from Beaumont that I've known for over 20 years. This is an exception to bed need methodology. Well, of course there's an exception to bed need methodology, that's why you are here. If we didn't need that, we didn't need the information, we would just ask the department to continue on and that was approved in 1970. I just want to remind you that you have made exceptions before right in front of my eyes. You made an exception for Beaumont. I was on the same Oakland Board serving at that point and time. That's only six miles from Beaumont running at 50 percent occupancy and Beaumont made it clear that they should be exempted from the bed need methodology because they were busy. We get that. We could have easily said let the patients go six miles. We didn't do that. A few years ago I remember Commissioner Maitland was chairing Metropolitan Hospital proposal came. At that time you exempted Metropolitan Hospital. You gave preferential treatment to them. You gave that outside of the two-mile replacement zone. In fact, it's not in alliance to commend it without, I think about six or months ago, and you approved the movement of beds within the same sub area from one hospital to another hospital without any occupancy standard. In fact, I testified shouldn't you at least put some occupancy standard. Shouldn't you require that if a hospital wants to move some beds from one hospital to another, you should at least require 60 percent. You allowed that at that time. For some reason you decided to support that. So, much for exceptions. You had a number of testimony on hospital construction cost. I have testified before and you can look at my testimony before that when we go to renovated beds on the Detroit campus, a hospital that was built in 1913, our architects and construction people have told us that it would be a lot cheaper to put in new beds out across the street. It does not conform. There's no way we can go back and renovate a bed. If you look at Beaumont, which has just spent $300 million to build a new bed tower. Why didn't they put their own beds right there on the campus? Why did they put the new tower just right across, a $300 million tower. Because that is the most economic way to put in new hospital beds. It doesn't pay to renovate new beds. So the hospital construction cost and so forth are just a bogey. Trinity has spent a $100 million to stay open. Crittenton hospital spent $15 million. I could speak to one after the other hospitals that don't need to come to your process, and on their site for these expenditures. I also want to remind you that no insured or Government pay the hospital additional re-enforcement. They just want to incur capital profit. It was once true that when build a hospital we would some how be reimbursed by the payer. Unfortunately Ford and GM and Chrysler in their infinite wisdom decided that they would not pay us a single cent more for building these beds. Now, some mention was made about, there was a general article that talked about, in fact, more competition. I guess, I too, and I can give you a dozen of these not to study them, I'm not smart enough for that. Professor David Drenall, Northwestern University being interviewed on National Public Radio asked specifically about the automakers concern about large health care beds going up because hospitals are being built. That was the question. The answer was the health care built of the auto companies are going down because they both cover workers that are currently employees and retirees. So, when we use this statistic, with our friends at Chrysler, like you, we are spending more for steel than health care. That's a very easily distorted statement. Maybe you can produce 10 percent less cars last year because you can compete in the marketplace, and that means the cost of healthcare will go down. The total cost is killing you, not the cost of health care for employed workers. Professor Drenall goes further to say there's no connection between that of the building of new hospitals except to the extent that more hospitals are more competition and

lower hospital crisis. This was a study. You already heard the presentation by Duke, which was authorized by you. That had the same conclusion. Maybe Duke is not good enough and Northwestern is not good enough. This is from Stanford, Professor Starty, published in Health Economics, 2002. "Higher hospital market share and lower quality in terms of inappropriate inflation services potentially avoid hospital complication when there is competition in the marketplace". At last I'll cite a study from Inquirer, this is from a Blue Cross/Blue Shield supported journal. A study from state of Washington published in 2002. "Competitive forces are prepared the same in hospital market as in most others. As for the competitive increase, prices decrease in market power share some suppliers and purchasers". So much for construction cost and hospital cost. The State Legislature recognizes these issues. We went to testify in the State Legislature, and after years of frustration there, they passed Public Law 619 two years ago, both Republican and Democratic Legislature supported the Legislation. It was one Governor Engler who signed that Legislation in December of 2002 and looked at these exact issues. I remember standing in front of Representative Ehart, who said the state was going broke. The state is going to have $2 and $3 billion deficit and we needed some relief and finally the bill was approved. For this and many of the people who testified in front of you, I would recommend that you move this to the next step, open it up for the public comment. At which time we have comments on the number of criteria that are here that you would like to adjust, but at least it would move forward in a constructive way. Thank you. I'll answer any questions.

CHAIRPERSON TURNER-BAILEY: Are there any questions? (No response) Thank you. Nkrumah Johnson-Wynn.

NKRUMAH JOHNSON-WYNN: Thank you. Nkrumah Johnson-Wynn. I'm an attorney with the City Council Research and Analysis. I'm here to read a statement of the Honorable Detroit City Council. I have a copy of the correspondence and I'll be happy to share that with you. It's addressed to the Chairperson, Renee Turner-Bailey, and it reads as follows: " As the members of the Detroit City Council, we urge the Certificate of Need Commission to favorably consider authorizing the 200 medical beds and 20 mental health beds requested by Unity Health L.L.C. We recognize the need for a full continuum of services and strongly feel that the current hospital will be a compliment to the agencies located in the Samaritan Center. There are a few hospitals in the Conner area. Therefore residents are forced to travel miles to receive medical services, visit relatives who are ill and receive urgent care. Careful consideration must be given to the fact that approximately 35 percent of the population live without a telephone or automobile. Citizens must be allowed access to quality medical care. This includes ease of access to medical services. Again we strongly urge you to grant the Certificate of Need to Unity Health, L.L.C., so that citizens may receive seamless services that they so desperately need". This correspondence is signed by Mary Ann Mchaffey, Council President, Kenneth Cockrel Jr, President Pro Tem, and members; Sharon McPhail, Alberta Tinsley-Talabi, Sheila Cockrel, Kay Everett, Barbara Rose Collins, Alonzo Bates and Joanne Watson. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions? (No response) Steven Scapelliti.

STEVEN SCAPELLITI: Commissioner Turner-Bailey and Commissioners, good afternoon. Thank you very much for this opportunity to address you once again on our proposal. I would like to open by saying that Unity Health supports the draft addendum that is before you. We ask that you vote to adopt this language as a means of getting to address the critical health care shortage in the city of Detroit. Now, and I'm going to paraphrase this terribly wrong. "But the journey begins with one step". We don't propose that this by any means solves all the problems of the city of Detroit, and although Representative Artina Tinsley-Hardman may feel like a 200-bed hospital in her community will solve the problems that they have with respect to the answers of health care. The city of Detroit has significant problems. As we have stated many times before this Commission, the city of Detroit is unlike any other place else in Michigan when it comes to health care. It's for that reason that we came to you first on February 26th and asked to authorize an additional 200 beds over and above the methodology and place at that time for the purpose of trying to address the critical needs within this sub area. Over the months since that day, you've heard a number of people come forward both in support and in opposition to this plan. As I stated before, there is no dispute but there is a need on the east side of Detroit and in other areas within the city of Detroit. We heard challenges with respect to real estate issues. We've heard challenges with respect to cost issues. We've heard challenges with respect to what others said they attempted to do but couldn't do. Yet nobody has

addressed the one thing that all of us are here to address, which is need. None of the statistical data that we have provided to this Commission has been challenged. No one has refuted it with anything to controvert what has been put before this Commission to show. That over the last five years, as five hospitals have closed on the east side of Detroit alone, nothing is going in to replace it. Not one aspect of primary care has been replaced on the east side of Detroit. Those patients that are left with no alternative must travel great distances and I will not bore you by repeating what we've said a number of times before. We are still waiting for one of our detractors to come forward with an alternative. Something to offer the city of Detroit. We've yet to hear it. There are plenty of nay sayers, but there's nobody to step forward and offer some type of solution. Now, I was encouraged for a moment with the idea that perhaps General Motors might step forward and give cars to those people who lived in that area who were in need. I agree with the Representative, that along with those cars, you need jobs. The people in that area are in sore need of jobs. Now, as for those who are with insurance, we have said we will take those people. The issue of an emergency room is not an issue in our eyes. We are opening with an urgent care center. And that urgent care will develop into an emergency facility. As our colleague, Representative Hardman's colleague, whose mother was injured and they couldn't find a place for health care, that person would have been welcome at a hospital ran by Unity. See, the principle difference an urgent care center and an emergency room really comes down to a question of regulation. When you have to take people who are able to pay or not or you have to turn them away. You can't do that with an emergency room status. However, each hospital represented here today, which is a non-profit, had to make a commitment with their tax-exempt status for them to be a charitable non-profit hospital, they had to make a commitment to the IRS for that tax-exempt status. They would take care of the people who couldn't afford to pay. This is going to be a non-profit hospital. We are determined to put a hospital in the city of Detroit whether the Conner location or some other location. One thing about this is that it will give us the flexibility, or it gives others the flexibility to put a hospital in the city of Detroit to address this critical need. Now, we're still understanding the effects of this language. We've done an analysis. We believe that this gives us the ability to accomplish what we first came here to accomplish. We think it is a significant compromise with what we've requested in the first place, which again to remind you, was an additional 200 beds over and above the methodology. I know there was some resistance both within and without the Commission to that concept. We see this as a significant compromise that will enable us to work in collaboration with those hospitals and hospital systems within the city of Detroit to acquire the beds that are needed and place them elsewhere within the city of Detroit for the purpose of providing care. These beds are not staffed. We presented this issue before to this Commission. The fact that you have issued beds is not equal to the concept of staff beds. This hospital's closed beds have been shifted from one close facility to another facility that remained open. I repeat we have no objection to that process. It is allowed by the statute and that's fine. But until you can look at the number of staffed beds and say that it provides sufficient access to the city of Detroit, you have not begun to address the problem. We think it's interesting that when someone comes before this Commission and challenges any proposal for addressing the health care situation in the city of Detroit, they always seem to come back referencing Unity Health. And someone said we should be flattered, we're not. We find it appalling that we are the only ones who have come forward with a proposed solution. Now with the support of those systems within the city of Detroit who truly feel that this proposal is the beginning of the process that will enable beds to be brought back on line within the city of Detroit, we believe that is progress. We believe that is something that will help turn around the health care problem in the city of Detroit. It is not a final solution. I can promise you in the years to come, we and others will be back before you with other solutions, other request, but this is the first step. This is a significant compromise and we think it will work. So we respectfully ask that you approve this proposed language. We also ask, given the fact that time, as we have repeatedly said, is of the essence with respect to this. If at all possible that a special meeting be convened between now and your September meeting for the purpose of allowing public comment on this, so that hopefully by the time the September meeting, this issue can be concluded and we can move forward. Every day that goes by, every month that passes, persons on the east side of Detroit and other places within the city are suffering. They are without health care. It is the purpose of this Commission to address this. There are procedures that have to be followed. We do not ask you to avoid those requirements. We are not asking for special consideration. We are not asking for anything that anybody else has not asked for before. But the people we should all be concerned about are not meeting. They are the other people that were sitting in this room. They are the people out in the state who require health care in the city of Detroit. In the city of Detroit that need is much different from anybody else because there isn't another answer. I thank you for your time and I'll be happy to answer any questions.

CHAIRPERSON TURNER-BAILEY: Are there any questions? Commissioner Goldman.

COMMISSIONER GOLDMAN: One quick clarification please. One of the prior speakers referred to 220 beds and 20 psychiatric beds. What you would be using is 200 beds. Which is the accurate number?

STEVEN SCAPELLITI: We have been before you asking for 200 acute care beds because that is what we really need access to. Our understanding is when speaking to the department, that 20 psychiatric beds are currently available. Once we open as an urgent care facility we won't have any difficulty obtaining those additional psychiatric beds. What we're here asking you to do is to provide us with the means of requiring 200 acute care beds. Our business plan which I provided you with back in February, does, in fact, address a 200 acute care bed and 20 psychiatric bed hospital.

COMMISSIONER GOLDMAN: On the question of ER versus some other approach to urgent care, are you thinking of opening up a facility that has an urgent care center that has 24/7 availability?

STEVEN SCAPELLITI: Yes.

COMMISSIONER GOLDMAN: So the thought is that you would open up an urgent care center that would not close, and up-grade that to an emergency department. Is that the idea?

STEVEN SCAPELLITI: That is our plan, yes.

COMMISSIONER GOLDMAN: Does this plan say when the time frame would be for that revision?

STEVEN SCAPELLITI: I don't believe the business plan does address that address that, no. We have stated, I think I stated the last time we were before this Commission on May 11th, that our goal to end the two years with an outside date of three years. Certainly sooner if the economics justified and allowed us to do so. We would open with an emergency room on day one if we thought that was economically feasible. As you've heard from all of the testimony from our detractors, they feel that a hospital can't exist at all. We disagree with that, but we certainly feel that the hospital would be more stable and have a better chance of success if we could have some ramp up time before it opens as a full fledge emergency room facility.

COMMISSIONER GOLDMAN: The reason that I'm asking is because you and other people are actually making two different points. You said patients are left with no alternative except to travel great distances. There's an unmet need. If that is true, then what are the unmet needs is for an urgent care, and one of your goals is to provide that care. But you also say you want to do it in a way that provides for economic solvency, which really means that you're going to be subject to the Ayatollah laws of Michigan because then you have to take anybody who comes through the door. Is that a fair understanding of what you're saying?

STEVEN SCAPELLITI: I would have to disagree with part of that. In the first place I don't agree that that is the only means by which patients can come to a hospital on an immediate need basis.

COMMISSIONER GOLDMAN: I didn't say that. I just said that there's an unmet need for emergency care in the area.

STEVEN SCAPELLITI: I would agree. There probably is an unmet need for emergency care. I would not disagree with that. Again, this hospital is not going to be all things to all people on the day that it opens. We expect to ramp up to those additional services over and above the emergency as time goes on. But patients have equal access to a hospital through an urgent care facility. In fact, there is a situation where it requires hospitalization. Like I said the principle assertion is or the laws should require that we take in everybody whether they have the ability to pay or not.

COMMISSIONER GOLDMAN: At least one of my concerns is, one way to fill beds is from referrals from primary care or community physicians. Another way to fill beds is that plus urgent or emergency care. A

great way to fill beds is through having an adequate surgical service that needs inpatient recovery time. What is the business mix that you see of how these beds would be filled?

STEVEN SCAPELLITI: Dr. Joe, who is also one of the speakers would be better to address that question. That's certainly outside of my knowledge with respect to our proposal. So I ask that you refer that question to Dr. Joe.

CHAIRPERSON TURNER-BAILEY: Any other questions? Commissioner Ajluni.

COMMISSIONER AJLUNI: Yes, one more thing. So, keeping this as simple as possible for me. You come to the urgent care center with chest pain and no insurance, which requires a person having an impending heart situation. What happens to the patient?

STEVEN SCAPELLITI: To the extent that we have the ability to treat the patient at that facility, we would admit the patient. If we do not have the services available to take care of that patient, we would stabilize the patient and move the patient to another facility that does, in fact, have that. I think we indicated that we won't be doing open heart surgery at this facility, but I understand the nature of your question. To the extent that we have the ability to treat the patient at that facility, we would take the patient in and take care of the patient.

COMMISSIONER AJLUNI: And not based on their ability to pay, but based on whether or not you have the appropriate medical facility?

STEVEN SCAPELLITI: That is correct.

COMMISSIONER SANDLER: Can I make a comment? If the patient that came in and they thought the patient had a heart attack, obviously an attempt to an Angioplasty, they could not take the patient in. I think that's what he means. If they thought the patient had chest pain but not a heart attack, then they could treat the patient.

CHAIRPERSON TURNER-BAILEY: Are there any other questions? Commissioner Goldman.

COMMISSIONER GOLDMAN: When you say that they support your proposal, you're saying that they support the entire proposal including the potential of moving beds out of the city of Detroit?

STEVEN SCAPELLITI: Correct. This provides us with a mechanism for obtaining the beds, so therefore we support it. Again, there are beds that are closed in the city of Detroit. They are not staffed. They're doing the city of Detroit no good. You have an over-bedding issue in the city. I think to the extent that those beds are located in the city, you're also preventing others such as Unity from being able to obtain beds, these care beds, to reopen or initiate new facilities within the city. I guess we have raised the entire proposal.

COMMISSIONER GOLDMAN: I'm not sure I understand that answer. The way that I read this is that it talks about tax replacement. It may be that you write the bed, but that's not being considered non-active beds. Maybe, Jan, you could comment on that?

JAN CHRISTENSEN: The pool was originally created on a two and a half percent total in licensed beds that was charged to the city, so it's not necessarily active beds. The two and a half beds were the total bed inventory. Each application that complies with the 300 beds, I'm not sure. I don't understand the relationship between the question of the beds in the city and the other one.

COMMISSIONER GOLDMAN: If a hospital in Detroit had a thousand licensed beds and were operating 600 licensed beds and wanted to move 300 beds to an adjacent area and give 100 beds to Unity, would those 400 beds come from their overall license capacity or come from their 600 currently active beds?

JAN CHRISTENSEN: The movement of the beds in the city under Section three, are active placement beds, so Unity would have to identify their partners in the city that would allow them access to active

beds.

COMMISSIONER GOLDMAN: So, if a hospital had 600 active beds and gave 100 of them to Unity, then the 500, if they wanted to put 300 beds in the Suburbs, that would come out of their overall capacity.

JAN CHRISTENSEN: Yes.

COMMISSIONER TURNER-BAILEY: Thank you. Dr. Khory.

NABIL KHORY: Good afternoon, my name is Nabil Khory, and I'm the physician in charge of Henry Ford Medical Center, West Bloomfield, and I'm an emergency physician. I want to thank you first for your willingness to continue to review this issue on access to care in terms of the population. I want thank you for this opportunity to comment. I hope, I'm going to be brief, but I do hope I can provide you with a little bit of a different perspective, and that's from the front lines in West Bloomfield and what our patients are experiencing. I don't know much about the bed allocation process. I have an administrative role in my facility, but it's certainly not in this capacity. But I do know that we have a huge issue population at the Henry Ford Health System. By size, I'm suggesting about 150, 000 to 200,000 patients. These patients are distributed in our Western and Northern regions. Of course that's the size of a medium sized city. The alignments are basically, in a large part, based on long relationships with Henry Ford doctors. If you ask, and I've heard many people this morning and this afternoon talk about is there a need or is there not a need, and again I'm not an expert. I would suggest to you to ask our patients. If you were to ask those 150,000 patients do you think there's a need for a hospital in West Bloomfield, I think they would uniformly say yes. I can tell you unachievably I have spoken with them and had conversations in that patient room with many patients. In fact, yesterday alone 10 conversations with patients who were being admitted, who I had to explain that we couldn't take care of them on the site. It was a tremendous, not only patient dissatisfied, but a tremendous inconvenience and difficulty for patients. When you need a Health System, I believe in Oakland County that operates on such a huge scope, and it doesn't have access to unction care, at Henry Ford, West Bloomfield, we're very proud of the very premier outpatient facility. We have an ER, an operating room, a Cancer Center, Clinics, labs, Diagnostic Radiology Center, and we even have a CatScan section. A few years back we opened a 23-hour facility to try to at least take care of some extended stay on site. However, it is clearly not adequate. We have a medical information system that's kind of our integrated health system. Within the Henry Ford System it's very, very useful. In our location we can only offer patients two options. Either they go down to Henry Ford hospital for admission, which is about 25 miles away, and 40 minutes or more, or to another neighboring facility. The down side for that, of course, we lose continuity of care, there's a number of patient hand offs, and there are increased cost to patients because the mast majority of those patients are being transported by what I perceive to be unnecessary ambulance services. This has hit home. As I get older, in fact, my own parents had similar experiences where they couldn't have their treatment done at our facility, and my father recently had surgery and had to go downtown to Henry Ford just by being a resident in the northern Suburbs. It's a real problem. We haven't been able to deliver the innovations that the Henry Ford Health System can deliver to our Suburban population. We have a world class surgery and technology, and unfortunately we can't provide operative care. I believe that having a hospital on site would minimize medical errors and decrease our emergency cost. The West Bloomfield and surrounding areas are certainly a growing population, and also an aging population. Transportation for the elderly is not just an inconvenience issue, it can be a real care issue, as their children are provided extensile amount of care even longer for the patient. We've estimated that by 2007, there may be a need for 120 more beds, even the current utilization continues. I think the aging of our population would ensure that. Much has been debated about different statistics. Again I'm not a statistician but I think a little bit needs to be said for the enhancement of care and providing improved quality. We have serious issues in transporting a large number of patients all across the metro area for on-going care, and then they come back to us and we don't know what's been done to them. We see duplicate of testing. We see a lot of management that might be inappropriate, given light of the patient's history, but our neighboring facilities don't have benefit to this. I sincerely believe that this is an access issue. It's also a quality of care issue. I say this as a physician and not as an administrator. I think it's worthy of your further consideration, and I hope that you allow this to go to public comment and this process will go forward. I thank you for your attention and thanks for this opportunity to participate in this process.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions?

COMMISSIONER GOLDMAN: Your point as I hear it, is that by establishing a facility in West Bloomfield, you have created in your patient population and you want to fill that need because a certain sub set of those patients need additional care that you can't provide at the site?

NABIL KHORY: This is my personal opinion. I think, yes, that's absolutely true. We have a very large align patient population. An argument would be that a large number of these patients require inpatient services every year, and I think it's very important that we able to deliver that care. By the same token, from what I hear from other hospitals who have added beds and so forth, their patients have demanded that, and they needed those services. So they have added beds. From our perspective, my perspective, I need a place to send my patients.

COMMISSIONER GOLDMAN: So, the University of Michigan outpatient facility across the street from you, and people relocated to the University Main facilities and things that the University was able to provide, your argument would be if they could go to Detroit, that kind of client satisfaction, they should be able to add inpatient beds to the other site. Is that correct?

NABIL KHORY: Again, it's a hypothetical and I'm not representing Henry Ford Health Systems here, I'm representing myself as a doctor there. I will tell you my view. We have been committed there since 1975 with an emergency department that have been serving about 30,000 patients there. We have been doing it under incredible duress. You can't imagine the critically ill patients coming in and not having a place to send them. It's a very stressful environment because it's a sub-optimal environment to patient care. I guess all I'm saying------

COMMISSIONER GOLDMAN: A sub-optimal environment, is that an emergency room without beds?

NABIL KHORY: That's correct. We don't have an intensive care on site.

COMMISSIONER GOLDMAN: It's a bad planning policy to go to an emergency room with no beds.

NABIL KHORY: We had an outreach to our patients. We do a good job at what we do. We haven't been able to expand from a continuum of care.

COMMISSIONER GOLDMAN: If you are a physician in private practice, some sub set of the patients that you see are going to need care beyond your capacity provided within your office. That's not an argument for a physician to have hospital beds, right?

NABIL KHORY: That's right.

COMMISSIONER GOLDMAN: It's your argument to have a facility that can provide appropriate continuity of care, which is what you give the physicians, staff physicians, at your hospital. I'm trying to figure out, as a planning principle, what the principle ought to be. One planning principle is if we can open up a facility under state rule and show that it is a successful facility, then we get to go to the next step and open up a different facility. A facility with beds. Another planning principle might be, you don't want people to open up certain facilities that will let go meet those unmet needs, like emergency rooms or urgent care centers because it is predictable that a sub set of patients go into those centers will need inpatient care, and there won't be any beds. I'm just trying to figure out what you're asking for.

NABIL KHORY: It's a different model certainly than a hospital model. Mike Duggan said that if the outpatient center as we have it, has a very important service. Particularly in 1975 in West Bloomfield, which was a very distanced Suburban, it was an important way to service a limited number of patients. As we've grown over the years, we've had tremendously ill patients. There is an increase in technology, increases to hand off, and that certainly saved on the emergency departments. It took almost 30 years to evolve this way, but I think that it's clear now that the facility is so well utilized that's essentially now a hospital without inpatient beds. So it's evolutionary, but I don't know that ------to answer your question I'm not a planner. There are a lot of units and models that has come into the country and where will all of

these facilities end up. I imagine that some may develop into hospitals and some may not. I don't know the answer.

CHAIRPERSON TURNER-BAILEY: Commissioner Hagenow.

COMMISSIONER HAGENOW: I have one question. Mr. Duggan said it's moving to outpatient, so what you've done is what the future is. So, why do you need beds?

NABIL KHORY: I don't think, and again this is coming from a physician's perspective. There are some surgeries certainly that are going from two day stays to one-day stay. There's no question about that. We also have a very much an aging population in the medical care for the elderly isn't much more intensive. So, yes, I think there are a number of trends in medicine. Some we're making in regards for shorter hospitalizations. As patients get sicker and older, and we have more technology to keep and better medication to keep patients alive. You're going to find that there are actually patients who require, some populations that are going to require more hospitalization. Again I don't know the stats.

COMMISSIONER HAGENOW: So, what you're stating is that you agree with the trend, but that doesn't take away from the need for inpatient
beds?

NABIL KHORY: I think there are different trends for different sub populations. For the young we don't require, we can do relatively minor surgeries, how a patient is a way to go, absolutely.

COMMISSIONER HAGENOW: Another question around. If there wasn't any competition, then you basically, even though they are aligned with Ford system, you would be sending the inpatient to a competitor's hospital.

NABIL KHORY: Frankly, we have to do that now. There are patients who cannot make it, and they'll tell us that they can't go to Henry Ford.

COMMISSIONER HAGENOW: But the barrier is competition. If there are access beds in the region and you're willing to send them there, and their willing to receive it, the real barrier is the fact that it's a competitive world and if they are aligned, you want the coordination of care within your system, but there really is beds there.

NABIL KHORY: There are particular need beds in other facilities and I don't know their statistics, but I think it's a quality of care issue. If a Beaumont patient goes to a Beaumont ER and they're full, are they sending them elsewhere? I don't know the answer to that, but my guess is that they're probably are not because there's the issue of continuity of care and to the ratio of health services and so forth. It's about better practice probably. That if someone's doctor is there, then they should there. By the same token I think we have ------well, we're experiencing the same thing.

COMMISSIONER HAGENOW: Very good, thank you.

CHAIRPERSON TURNER-BAILEY: Are there any other questions? (No response) Dr. Lonnie Joe.

LONNIE JOE: Thank you, Chairperson Turner-Bailey and Commissioners for giving me the opportunity to speak. As you can see I'm suffering from something. I know there a lot of good doctors in the room. I'm happy to be here today to testify again before the CON Commission concerning the health care needs as they exist on the east side of the city of Detroit. I've heard a lot of comments today, and I am also happy to report that the ability to have this discussion with major health care centers have certainly come a long way this year. The discussions may not have been pleasant all the time, but I think these discussions were sort of like dating. There's no conversation. There's certainly no whatever. Hopefully since we believe in doing things the proper way in this country and following rules and regulations, we hope these discussions can lead to a marriage of sorts and hopefully produce a baby. Something will be conceived out of this that we will own up to. Like parents own up to a child and say, yes, this is our product. I think everybody has a stake in that, the Commission included. Again, I read the preamble that was referenced to the

Commission's charge, and some of the statements that I've heard today from the community, and this is more addressed to the community than the Commission. One of the wonderful things we have in this country is called free speech. It gives us the opportunity to say whatever we please. However, some of the things are wrong. Outright wrong. They don't reflect the body of knowledge that exist within the health care arena. It certainly doesn't reflect the years of experience that we know, that we know for a fact exist inside; these institutions, whether they are insurance companies, whether they are private businesses. We certainly know they don't reflect to some degree the conclusion that has bee arrived at only reflect to some degree. The knowledge of the health care systems, what do they reflect. They reflect to the response to what the rules and the regulations are that people have to address and live by. Contrary to your popular opinion, the gentleman who spoke earlier about sausage and laws, you don't have to eat sausage, but if your intent is not to follow along, you probably have committed a violation of that law already in your heart. Therefore we see outcomes like we do now. Mr. Duggan referred to me as a businessman, I'm a physician who just happens to be doing business, and most of the physicians I know, they are all becoming physicians who happen to be better businessmen as the day goes along; some out of necessity. However, Mr. Duggan referred to David Ellis' comments, and I think if we're going to toss these things out of there, we have to be factual about them. There are just as many down sides that Mr. Ellis comes out in terms of future health care as we see it now. In terms of system operation. It's based on what we've done in the past. It's based on our history. We report not about the numbers, but guess what, we fail to understand the outcome of our actions, such as the mayor. It is the failure to examine the outcome properly. Let me give you an example. Out of the east side of Detroit, given its present condition through rules and regulations and conditions; how did healthcare get in this condition? Insurance, get intentions. But out comes that a war. He discussed the service well. As a result, the preamble of this Commission is not that you make rules and regulations that are etched in stone. It is incorrect for the community to be allowed to think that it is. It's your job to accept the change for what it is, as it comes to you. They need to understand that. I know that most of you `understand that. Again these comments may be to the both of us. Rules and regulations exist for a reason. If you run that stop sign down the street from your house every morning, you didn't run the stop sign until you got caught or had an accident, well, folks, we have an accident on our hands. In the Institute of Medicine report, if you haven't read it, then you need to read it. You need to read it so that when people come to this microphone and they state this, that they have interest other than what this Commission or what the state of Michigan is supposed to be doing, you can see the difference. You can sort through what is factual and what it may represent. Well intended interest on another part from another source. At the same time you have to be able to find focus and shine the light on these issues. I'm a physician. I'm so glad to see Dr. Smith and Dr. Khory here today because I was feeling lonely up here being the only physician at this microphone over the last several months. However, I echo their sentiments. It is not possible for a health care delivery in this country to continue the way that it is. If we don't begin to embrace the new ideas, new approaches that are based on sound judgment, factual data, we will not do anything but see you next year, some of us. The issues will stay the same. We may change. The Commission certainly will change, but the outcomes won't. The outcomes, the measurable outcomes will not change. Therefore, when we talk about emergency room situations have to go, we have to realize that they're just fine tuned, and there's an understanding that has to be brought forth in terms of the emergency room. Sixty percent of the emergency rooms that were overloaded in the city of Detroit and the Suburbs, 50 percent of the people who show up don't belong there. When we talk about providing relief, we talk about taking a percentage of those patients at some time in the future and putting them in the proper setting. That can only be done if we provide change now. It is not fair for people to use rules and regulations that are bad laws, only when we don't have the ability to change them. We have the ability in the state of Michigan according to the law. So statements such as getting around the CON Commission, I think is non-sense when the issues are brought here time after time again and brought to you. For the public to walk away with that perception, I think it is ridiculous. I think that if their not served, the issues, properly then it certainly doesn't serve the citizens and we do a disservice to the patients that we attempt to serve in the city of Detroit. Remember, and I hate to tug on your religious persuasions, but remember the law used to be no healing on this Sabbath. I'm certainly glad that most of us are glad that that law went away. Until we recognize that this is a work in progress, it has to evolve. I am a work in progress. I'm used to being two suit sizes smaller than I am now. Because of my ability or inability to maintain that size, things had to change or something had to be triggered. I could have shown up here in tight pants or I can go and buy a new suit of clothes. This Commission is forever changed. That's the beauty of the Commission. That's the beauty that it operates under. Therefore, as a representative of Unity Health, we respectfully request that you consider these changes in whatever light you deem necessary. Whatever light you think

is best to bring these forward, out, so that this health care community, not just spaces, which is what I thought this was all about. But people who have the responsibility to make the decision that effect patient care, believe whether or not we get automobiles or not in our communities. Those kind of decisions have to be taken and made in light of, in view of, how this affects patient outcome. Now, if we decide that we're going to have population divided to the degree that we have to treat them differently, then let's do that, or let's own up to that decision. If we're going to have one Michigan, as the Representative said, I think it has to start with one approach and one understanding of what the relevant facts are. Because of that, we have people like Dr. Khory testifying about the seriousness of the decisions that were made in the emergency room. People did not understand the relative connection, the direct and indirect connection between the decisions that were made here in Lansing, CON Commission or otherwise, and how it affects a physician practicing in the community, in the emergency room or otherwise, maybe, maybe they need to get on board on the education side of this. I'm always reminded that 20 years in the industry is sometimes one year of experience 20 times over. It does not affect 20 cumulative years of knowledge or commitment. Therefore, we respectfully request that this Commission takes this proposed Legislation or takes this proposed standard change, and not Legislation, but take this change and do what you need to do with it to achieve the proper outcome. Because if that is not done, you have to force the hand of people sometimes to do the right thing that is not done. Right now in Detroit an international conference on Hypertension is being held. It started last Friday morning and it ends tomorrow. They come here not only from this country alone, but from all over the world. They come to a city where the levels of treatment of Hypertension control are below the national average. We've been tallied to be the fattest city in the state. The fattest state in the country, which makes us the fattest people in the world. As a result of that, we see disease states run ramped and out of control. It took visitors to our city for 48 hours to recognize what the lack is in the city of Detroit, and they don't even know the politics. They are not impressed by Casinos. They are not impressed by football stadiums or baseball stadiums because they know those things, for the most part, would be dealt with on a political arena, and the consequences are minor. If anything there may be some benefit to a community. At the same time people went in the trenches for healthcare, fighting against disease that is driving our city. They came here and said "you know what, you're missing the boat, Detroit". We need your help to correct that. It has to start here. With that in mind we look forward to the next level of change so that we can address it properly. Keep in mind, all of us are getting older. I'm not pregnant as like the speaker who came up before me earlier today. At the same time it's just a matter of time before you or your loved ones or anyone in this room is going to dethrone the health care system. How many people in the room take medication? Raise your hand. With that in mind, we know that all of us are going to need this healthcare system. Behind that we're going to need sound laws that are thought through and that are subject to change when the time comes. I would hate for someone to be say that we continually wear the same size shoe. It doesn't fit after awhile. You move on and do bigger and better things. You profit from your mistakes. You learn from your experiences. We look forward to continued discussion on this issue. Not just with the Commission and the Legislatures. We still look forward to this discussion, the continued discussion with the people who were in the trenches with us in the city of Detroit. The Health Care Systems, we are happy to report that the more we talk, the better that this gets. We're looking at from the standpoint of you that we can change this situation in the city of Detroit that exist for a certain segment of the population. Thank you and I'll answer any questions.

CHAIRPERSON TURNER-BAILEY: Thank you. Are there any questions?

COMMISSIONER GOLDMAN: On behalf of my mother, thank you for making me a doctor. She would appreciate that. Your example with the Hypertension problem. You said that people came and within 48 hours they recognized the problem. What was their recognition of what the problem was?

LONNIE JOE: All they had to do was interact with people here. You can't drive the street necessarily and see the total problem. But they come here knowing the people in this community. They have had relationships that have been around the years. When you interact with folks, what do we do when we get together as doctors? We talk about issues surrounding medicine. These people can sit you down and after a short period of time, say, "yes, I understand what you're going through because you don't have the tools to do this".

COMMISSIONER GOLDMAN: It's a very specific question. It's my understanding, and I am not a doctor, is that the problem with Hypertension is that it's the silent disease. If you don't have a primary care physician,

it doesn't get diagnosed in a timely fashion. You don't get appropriate treatment. At some point in the future you go into an urgent care center or an emergency room with a Hypertension crisis, and that's when you need that intervention and that's when you need a hospital bed. So, I've always been taught that the solution is primary care and not hospital beds. Is that a fair statement?

LONNIE JOE: That's a fair statement if you lived ten years ago. The future is that there has to be not only continuity of care and that primary care is only one piece of the picture. We made this mistake two or three years ago by allowing public reception to leak out in various forms when it came to hospital beds. This community never should have had the impression to the degree it did. That beds and systems would be used in the city. What did the people south of Eight Mile think of Michigan? That clinics were okay for the city, but hospitals should be in the Suburbs. I don't think that was the intent of the system. I think it's a multi-factual or problem that says if we don't look at the full scope of providing care, we'll only going to solve one little small piece of it, and guess what, we won't make the impact in any disease including Hypertension.

COMMISSIONER GOLDMAN: Maybe you can answer the question that I asked earlier. What is the business plan for filling the 220 beds? What sort of patient mix do you see both in terms of insurance coverage and in terms of kind of conditions that would require them to use the beds.

LONNIE JOE: The conditions are stated in the business plan in various forms. We can talk about what exist in that area. Whether it is Hypertension, Diabetes, Asthma, we can go there, but those will generally turn into a medical discussion. How do you provide for that community and how do you put the surfaces on line and it turns more into a business discussion. It stands to reason that you would kill a plan like this if you demand it on day one that emergency rooms open now. If Trinity, St. Johns or maybe Ford wants to donate some money to the cause and start an emergency room day one. Who's going to come up with that fine foundation that my friend runs over there. Those things are possible, but from a business perspective in our proposal, we did this in a manner of looking at not just today, but what the long run is because we knew that eventually the emergency room would be needed in that area. It's needed now, but how do you get there is the question. We've answered those questions on how to get there. So, when we look at these things, we look at the payer mix. Remember my prior testimony through the Commission. We know what's happening there. There are four housing projects, three are done, and a new one is under way. You can't buy those homes for under $200,000. People don't necessarily buy homes everyday for $200,000 without a job. Those jobs usually have insurance. We're looking at the real ability of this community to support a hospital. Not in the fashion of traditional accounting standards. Why? Because we don't have to invest in the facilities to that degree. We're looking at an old fashioned approach with a modern response and modern outcome in order to satisfy these critical needs. In fact, it would help satisfy the critical needs. So, the mixture is what this is all about. The mixture actually focuses on how you actually hid some of those diseased states. It's not fair to think that a community like that, if you dry it, then it produces third world numbers. We have numbers in that community that are worse than Beirut. That are worse than any third world country that you can think of. Right here in the city of Detroit, we can begin to do something about that. We get a two to three percent increase, we're going to be happy that we're headed in the right direction in certain areas. Did I answer your question?

COMMISSIONER GOLDMAN: I don't think so. The prior speaker talked about Henry Ford hospital setting up in West Bloomfield, an outpatient clinic that gradually grew over time to be an outpatient clinic. It had an emergency room, it had observational beds, it had surgery. He said he was ramping up towards a time where he had a patient population when there was a need for beds. What I think I hear you saying is the other side of the coin. We have a patient population that has a need for beds. We want to start with the beds and then we'll ramp up to emergency room, outpatient, primary care, for continuity of care. I hear both of you talking about the continuity of care. One talks about ramping up from 1975 to now to where they didn't start off with the beds, and another said let's start with the beds and then fill the rest of the infrastructure. I'm just trying to see if I'm hearing you correctly.

LONNIE JOE: Yes. The point is not necessarily where we start or where we end. That's not the point. You will find that at the end of any particular time period the same types of services that are rendered at Henry Ford West Bloomfield, will also be rendered at any other hospital in this state. It's just a matter of which point on the calendar you choose to look at. So, we're not concerned about ramp ups. We

understand that end of the industry. We understand that end of the business. We know that over time, we will do certain things very simpler. You treat heart failure the same way. There shouldn't be any difference in the treatment in West Bloomfield or in the city of Detroit.

COMMISSIONER GOLDMAN: I'm looking at, you just said for example, that there was a need. Again, my understanding is that, and I'm sure that it's adequate. That some of that need has to do with childcare. Some of it has to do with obstetrics. Some of it has to do with newborns. It seems to me that you can't identify what your biggest needs are in the interest of a business plan.

LONNIE JOE: You're exactly right. That's why we included all of those approaches in the business plan. We say that it stands to reason that if other major health care systems with serious money stood behind us, then we wouldn't have a problem. That wouldn't be the place where we would want to start.

COMMISSIONER GOLDMAN: Thank you.

CHAIRPERSON TURNER-BAILEY: Commission Sandler.

COMMISSIONER SANDLER: Yes, I wanted to make a comment about the OB. Now, in the Henry Ford Health System they deliver close to 200 babies. That's a very small part of the health care that the Henry Ford System gives. There are ramifications to that, but that's a relatively small part of the health care of the system. If you were to look back to the 1980's in the city of Detroit when there were lots of small community hospitals, a number of them did not deliver maternity care because you had to have 500 deliveries, I think. You had to set up a license. You needed a bunch of other expensive things to maintain. It was not necessary that every small community hospital deliver maternity care. They had to provide services to the community. Obstetrics is only one service that a hospital could provide. Therefore, whether Unity should start a hospital on the east side of Detroit or not, is a separate issue than the OB care?

LONNIE JOE: That's correct Dr. Sandler. As you know hospital operations are a multi-factorial situation. The ability to address all of them in a bedded type fashion is not there in a lot of hospitals that already exist in the state. A lot of hospitals do not perform neurosurgery and so on and so on. The other thing that you have to keep in mind is the patient at times belong where the care is best. I would hope that we are thinking along those lines, that the patient belongs to the best setting for proper care. That's where we come from. It is not that you intend to do things that you don't have the ability to do, God forbid, we're talking about providing a level of care in a specified service area, that we can definitely achieve.

CHAIRPERSON TURNER-BAILEY: Thank you. Larry Horwitz.

LARRY HORWITZ: Larry Horwitz, Economic Alliance. Are there others beyond me yet? I'm going to do the most popular thing in the world and do this very fast, just out of sheer exhaustion. I think this last presentation identifies where are concerns are. Members of GM, Ford and Chrysler talked about the details of these different projects. I don't need to cover that. I want to talk about the overall issue of the process and fundamentally the decision that you now have to make. You now have to make a process decision. Are you going to send this thing to the Standard Advisory Committee. That's a specific decision that you have to make. What you've been dealing with contrary to any allegations more broadly than anybody else, both the opponents and supporters have dealt with this in terms of specific projects. Henry Ford and St. John has come in before you, yes. Other people have come in, no. But everybody is focusing on this. Nobody is talking about this in terms of overall policy. I suggest to you that that's telling you something. That what is driving all of this is trying to see what the Commission's process to achieve objectives on a particular project. That's happened before. Is that really the best use of your time and activity. Our concern is that if this process goes on to be made a special Ad Hoc deal where you'll pick your circumstances, absent some kind of broad policy justification. It discredits the process. It continually builds up in Dr. Sandler's memory and everybody else. That this is just a game of politics and pressure. When they rebuild the system, they had a rather dramatic up serge. People hadn't looked at that. It was after the time frame. A dramatic up serge in boutique hospitals, for profit hospitals. Especially hospitals that specialize in heart and other things. Free standing surgery centers and MRI's. Not all over the state, but over-willingly, but not completely in the top 25 percent of counties in Ohio based on income. The CON is good for keeping health care inside the city areas. CON was good in Genesee county when Norma's

predecessor, based on the CON 17th Act, took four hospitals and closed them. Dramatically reduced by hundreds of beds in the Flint area, and out of that was able to gain job opportunity without comparative review of building a hospital outside of a clinic, the Southern part of Genesee County. That's a success story. We would urge you to put something in the CON standards that would promote that kind of activity that was just pursued. If there was, in fact, a demonstrable need in any of these areas. So far we haven't seen a need for inpatient beds. Not a bed based on other criteria, but a need for inpatient beds, then we certainly would agree that the winners of that need should be very much based on whose got a better record of Medicaid. Who has the experience on viability. Those are provisions. Who has a better record on indigent care. Most of those criteria are already in your Certificate of Need law. This Commission's never been able to rationalize. We have a scarce resource, a viable resource of building yet another hospital. It's great to let that go to someone who has a good track record. It's in that lost for her to give out these Certificate of Need's to build new hospitals in areas that don't need new hospitals. Our judgment as a Representative of the Raya companies, we're desperately trying to keep the underlined economic reality to stay together. I know Dr. Joe is an associate and mentioned that. Our jobs are telling you that unless we try to restrain the rapid escalation of health care cost, we're not going to be able to keep the jobs here. That would be the single worse thing to happen for health care status then anything other thing you're talking about. Why do we focus on cost. They said it wouldn't cost anything. Sure it doesn't cost you anything, and the day after you open the hospital. We used to have a system where capital cost was a billed item on your bill. But that doesn't mean if you spend $525 million, as Henry Ford and St. Johns, as their numbers say they spent, and increase their expenses by $314 million on a third year operation, does that money comes from either? That money is probably going to come from revenue taken away from some of these other hospitals and some will net add the overall health care system. When our members sit down and negotiate with the hospital industry every few years on a participating hospital agreement. The underlined cost structure of a hospital community went large by these peer groups, comes to the table and had all beds built into it. It would be saying that if the hospitals and state accept something higher, watch more doctors and nurses or it affects other things. If you don't have several, you build it. That wouldn't impact the negotiations. We all know that. We know what we're saying to you when we ask you not to solve the ------the state Government has a problem. It doesn't have as much money as it used to have. It doesn't have enough money to fund Medicaid and indigent care. Even at the level of four years ago, not to mention the fact we have to have an increase. They are trying to solve that problem via a regulatory problem mechanism that wasn't set up to fund Medicaid and indigent care. We're saying that if you go ahead and do it that way, you can compound the problem. As we look at the data received, the bed need numbers show that there's no need. So, we just completed the second survey of the five hospitals. We are already in Novi. That's where my office is. There's been an eight percent decline in patient stays among five hospitals within a 10 mile radius of either location. Now, 47.7 percent of combined occupancy to 46.2. That's a lot. What's the conclusion as to what I would urge you to do. Have these issues, and I know you will disagree with some of them. While the Standard Advisory Committee considered it, they thought that's what you wanted them to do. It was a reasonable thing because the charge you approved said increase of licensed beds in a hospital already licensed. And the physical relocation of beds from one licensed site to a non-licensed site. That's what you're talking about. That's what you put in the charge. The first sentence of Access is "the material is covered by this document". I want to say that I think you're far better. If you send the public hearing and you get the opportunity to sit down and listen for four or five hours with a tape recording of people giving speeches with no interaction. I haven't seen very many Commissioners ever take the opportunity to ever go and listen to those testimonies. It isn't written up for you. It's a waste of time. It's an absurdity. We would have a few occasions where the Commission has said come to the public hearings, but most of the times they don't. Most of the time there is an interactive process. Again, as I emphasized, if someone could show us that there was a need for additional hospitals in any part of the state, we would support CON changes at additional hospitals even though we would tell you that it would drive up our cost. If it's a need based on access or quality, then we should go ahead and our members in the private sector and state through public spending, should step up to the bar and pay up. We will be ready to do that. But you first have to show this need, which is the role. Not by looking at the particular projects, but by creating public policy that make sense. So, we would urge you to say that we can make an exception, that's what you're here for. The case has not been made for a CON differential standards for any proposed new or reopened hospital anywhere in the state in an urban or Suburban or rural location. We're not saying that we would make that judgment independently and separately. Based on the information that we have now, we have looked forward to participating and a derivative, science and data base process, which Jan talks about in the Standard Advisory Committee. There are members who

will participate in it. We hope you let that happen. I'm glad Mr. Maitland made the motion where some years ago he didn't want to go, to the Ad Hoc Committee. So, you're making progress. Thank you very much.

CHAIRPERSON TURNER-BAILEY: Are there any questions? Commissioner Sandler.

COMMISSIONER SANDLER: I have a comment to make. A point of clarification. The public comment session, it's my understanding that the department records everything which is said. This is put on transcripts and sent to the Commissioners. I can't speak for my ten colleagues, although I bet it is true for them as well, but I read this prior to the meeting. Isn't that correct?

LARRY HORWITZ: This is sort of eliciting my comment. You'll find the public comment statements are not going to be caroli different from the eloquent and brilliant comments that you've just heard in the last six hours. You would get my reading the transcripts of those subsequent public comments---------

COMMISSIONER SANDLER: My comment referred to the fact that it's on tape somewhere and we don't have access to it, is what you said. We do have access to it.

LARRY HORWITZ: I did not say that, Dr. Sandler. I said that it's been my experience that it's been very rare when Commissioners have attended the public comment session, and very rare for Commissioners to go down and read the illumines comments that sometimes develop. You may well be an exception.

COMMISSIONER SANDLER: We get this material. We have the office to send it to us as part of this book. It's not so illumines that you can't read it in a reasonable period of time.

LARRY HORWITZ: I'm only saying that in my best understanding in talking to some Commissioners, is that they have not carefully gone down and read all of this. Many of them don't go back and read it because frankly it's quite duplicate of what they just read, what they just heard. I had an opportunity to be here for four hours.

COMMISSIONER SANDLER: And we've enjoyed that.

LARRY HORWITZ: I'm sure you have. I think it's the indirect process that allows challenging and questioning and clarification like Mr. Goldman and you have done with some of the witnesses, and that's far more useful.

CHAIRPERSON TURNER-BAILEY: I said there weren't anymore after Larry, but I have another card. Bob Hoban. Is there any further questions for Mr. Horvath?

JAN CHRISTENSEN: I have one comment with respect to Mr. Horwitz's comments. I think the public hearing process is a good process and I'm glad it's here. The most recent standard you adopted on MRI, we've had comments from the public hearing, which caused the change in the MRI standard that you adopted. It was exceedingly helpful with the viability of that standard and its work on behalf of the citizens of Michigan. We did make two changes at the last Commission meeting based on input at those public hearings. I think you probably will have something to say, some testimony of the public hearing on this standard, but I think you'll also hear a lot more testimony, perhaps it wasn't present today, but it was put out for public hearing. I think you have an opportunity to deal with that. I also suggested that given the gravity of this issue and the importance that a number of people that have should, that it's much more likely that the public hearing testimony that was received on this standard will be read into part of the September meeting, and digested thoroughly by not only the people who made the testimony and everybody else's testimony but the Commission's part as well. I would imagine that you probably have a third alternative from Mr. Maitland's recommendation. Which is perhaps a little different. I've heard a lot of testimony and a lot of it the Commissioners have here today, but why doesn't go to the Special Ad Hoc or our Special Advisory Committee. I will express my belief that it's my understanding that a Special Advisory Committee was formed for a slightly different purpose than this particular standard that's being offered here today. The fact is you could do both. You can turn it loose for public hearing. You can come back in September and at the same time you ask the Special Advisory Committee to make a review of it and make their

recommendations in September. That would not slow down the process, and it will allow you in September to make a definitive decision based on the considered Special Advisory Committee, and all of the public testimony that you're likely to hear.

CHAIRPERSON TURNER-BAILEY: Commissioner, just one issue in question I guess about putting any standard forward for public comment. I agree with you, but I think the public comment period is seemingly important. I've seen a lot of good changes that were made to the standards, but very often that's not the point where we're crafting standards. Those standards are essentially complete normally when we send them, and those really put the recommendations on the Commission. I guess my hesitation is use the public comment period as a way to sort of formulate whatever the standards are. I would rather see us get to the point where a standard is------that we're ready to say that we're recommending this standard and maybe some changes might be made within the public comment period, but certainly not ------here's a basis for a standard and we'll listen to public comment in order to solidify it. That's my own personal feeling about the public comment period. I think it's important that the Commission understands that when we send something through public comment, it's heard for recommendation. Commissioner Maitland, do you have a comment?

COMMISSIONER MAITLAND: Well, I agree. I was going to say pretty much what you said. When reasoning, we didn't have a lot of discussion changes for an Ad Hoc Committee just because most of the issues were resolved in that discussion. That's why I think it's so important to send this to a Standard Advisory Committee because if we don't, we're going to have so many issues brought up that I don't know how, we as a Commission, would sit here and resolve it after the public comment period. I agree with you 100 percent that that's the reason we should send it.

CHAIRPERSON TURNER-BAILEY: Bob Hoban.

BOB HOBAN: I'm Bob Hoban, and I'm Senior Vice President of Strategy and Business for St. John's Health. I just want to make a couple of quick response to what you heard this afternoon. First and foremost, there is an access problem. There's one hospital on the Western half of Oakland County. There are other access problems around the state of Michigan. We haven't changed the replacement zone, the two mile rule, in 30 years. Think how the population has shifted in 30 years. I used to go out to Novi in 1973 to the Novi Road exit at I-96 and deliver to a farmer's market out there. I used to eat my lunch on a road and said you can't see another building in sight. Yet, we sit here with the same standards that were crafted 30 years ago in the state for providing access for care. There not. Novi is keeping a log, the Police Chief in Novi, of all the serious health issues they've had in Novi because there is no access to new patient care. It's an issue. When we brought a similar issue in the fall, you said wait to the sub region read that Commission. I would posture it done and access is in the works. We've made the chances for resolving access to care issues more problematic by the sub region definition. We've got to do something to law access to care. That is why these things come to you on an exception basis. I don't think sending it out to a committee, a sub committee, where there are competing interest worry about maintaining their franchise rights to the patient. It's going to get to a resolution. Some people on the Commission will have to step up as a Commission and take charge. Another thing, cost. Allowing more hospital beds does not drive utilization in patient care. I think that's an accepted fact by the Commission. There's not many physicians who say to a patient, "I'll put you in the hospital because I have a bed available". I think those days are no longer. From a payer's perspective, the more choices that I have, in terms of who I can bargain with and who I can contract with, from a payer's perspective, my cost goes down. To an extent, you'll limit access to care and continue to create geographic monopoly, you're actually elevating the cost of health care, but not opening up access to care in Southeast Michigan. You're not leading the payers in a negotiating position. There are people in this room who virtually have geographic monopoly and can command much higher prices for inpatient beds than they would otherwise. Why is it that you're on exception basis? We've been talking about it for two and a half years now. One of the reasons that its here, quite honestly, is we're looking to make significant commitment in Detroit. We have approval for expenditures exceeding $200 million in our two Detroit facilities. It's difficult to look into the future and make that level of commitment and not knowing if we're going to be able to balance the commitment we have to the uninsured and under-insured in Detroit by having access to a broader geographic region to balance it fairly. You can put it into the SAC if you want, but I'll assure you, I'll bet you a lunch right now, the ultimate will be a stand off. Because you're putting it into a group where there are interest competing interest protecting the franchise

rights. We need to step up as a Commission, and I ask you to put it out to public comment right now, and come back in September and we will bring officials from the city of Novi and citizens from the city of Novi to talk about some of the access issues that we don't seem to want to acknowledge in the room. We can talk about access for the hospitals within a 10-mile radius. We don't talk about the occupancy of hospitals within a five-mile radius, because there aren't any. I can assure you that if you drive out to areas like Novi, you can't get to a hospital in a safe amount of time. We haven't changed access to patient care in years. Far too many years. As a Commission you need to step up. It will increase access, it will reduce the cost of care to the payers and to the consumer, and it will result in better quality of product because you can deliver better quality. When I look at your charge as a Commission, and I look at those three criteria, I ask when will we have it. That's the end of my comment.

CHAIRPERSON TURNER-BAILEY: Any questions? RON STYKA.

RON STYKA: As your favorite counselor, I do want to point out that under, and I realize there was testimony that stressed this, but under Section 22215, the Legislature has, I think, exhibited it as a pen. That first you come up with language, either directly using the system, and then you go out to public hearings simultaneously as you're sending it to the Legislature Committee. So, doing the Advisory Committee and public comment, it's not really strictly outlawed or forbidden under the language, I think it's pretty clear that it's not constructive.

CHAIRPERSON TURNER-BAILEY: You're making the point that I was trying to make in a more clear way from you looking at the language, right? We have to understand that this is not a process that was meant to be used to create or manipulate language?

RON STYKA: When you create the language first, we wanted the three processes which would directly, with the help of Ms. Rogers and the Advisory Committee's assistance, and then you go to public comment, and at the same time promote safety.

COMMISSIONER SANDLER: I would like to talk to the clarification of this. If the mildest thing you can do is comment on this, is that department and the help of other people can------it used to help with public comment such as we did on rural MRI for example.

RON STYKA: What happens is, that means that this Commission is moving towards adoption of that language. It's not creating the language through the process.

CHAIRPERSON TURNER-BAILEY: Through the MRI case, we used the Commission ------

RON STYKA: I'm not saying that it's not proper to use public comment for the language if that's what the Commission wants to do. The suggestion was that there was a third alternative, which is you go to public comment with this language simultaneously, you can still write crap in the language.

COMMISSIONER SANDLER: That's the impression that I have from the department. That this is a reasonably finished document that may need to be fine tuned to have public comment. No different then rural MRI's, Litho-piercing and numerous other things. Is that correct, Mr. Christensen?

BOB HOBAN: You're addressing something that I didn't address.

COMMISSIONER SANDLER: What did you address?

BOB HOBAN: There was a suggestion made that instead of you deciding you have something here that you want to work with, that you want to go to public comment with, that you have a public hearing and you'll still be possibly re-drafting or drafting something totally different while you're doing that at the same time. That's not the way to do it. That's my only comment.

COMMISSIONER SANDLER: My response to that comment would be that it's not the intent of the department. It is the position of the department, Mr. Christensen, correct me, that is a reasonably finished document.

BOB HOBAN: That's their contention.

COMMISSIONER SANDLER: That's correct.

CHAIRPERSON TURNER-BAILEY: Thank you. Is there any further discussion on the motion on the table? Commissioner Hagenow.

COMMISSIONER HAGENOW: I wanted clarification on the general likableness. You said at the beginning that this is a general liable statement. Otherwise we'll have the same issue as the last time when we were attempting political football where you can vote and can't vote. I want clarity on that.

BOB HOBAN: I don't know. What you're asking is fact driven and I'm incapable of replying because I don't have the expertise to say which say which hospitals may or may not qualify to apply under this et cetera. If, in fact, there's only the two same hospitals, then you may have the same problem. If, in fact, this is generally applicable and I cannot tell----as a lawyer, that's fact driven. That's for you to figure out and maybe as a group figure out.

COMMISSIONER HAGENOW: My concern is to not lose the work that's gone on it to this because I think there's a lot of work here. So, if there is a way that this goes to the Committee that's already set up and isn't just politicized. I mean that's the inference that I heard, but I think there must be some way that ------ what happens next after that? If we put the content to that group, then what happens? I'm asking two questions. The other one I'm putting on hold about general liable or not. I'm just basically saying, well, how do not lose what I think was a lot of work. The department didn't just sit there and just fiddle around and do this, they put a lot of work into this and I'm wondering how it is that that can be well utilized?

BOB HOBAN: It's the normal way.

COMMISSIONER HAGENOW: I'm still trying to figure out when is it a hearing and when does it becomes a committee -----that can get lost in committee.

CHAIRPERSON TURNER-BAILEY: Our Standard Advisory Committee is time bound. That's the one important change that has been made. One of the many changes that was made with the new Legislation. The work of the committee is time bound. We responded to the department's request to step up a Standard Advisory Committee because there was a lot of feeling and understanding that the bed need methodology as it stands today is not maybe addressing all of the issues that we might want to deal with relative to access and other issues. I think that's why we made it broad, the charge for it, which we also adopted as a recommendation of the department to allow that committee to take a look at main issues including, I would expect, this language. Give us a recommendation for language to move forward to public comment that has included not only payer mix issues but other types of access issues that we've asked them to look for. So, I don't think -----I absolutely do not think it's lost. The motion on the table is to ask the standard to move this language in particular to the Standard Advisory Committee to include and it's worked, that' we've asked it to do. I think we've, and I will use the word "we" and say that we've been very careful in choosing the members of that committee. But we, again, accept the recommendations of the department as a group to be members on that committee. I think we adopted that, we accepted it and we were unanimous in that. So, I am going to support the motion because I believe we should allow the committee to do it's work. Commissioner Sandler.

COMMISSIONER SANDLER: I think you should ask Dr. Ajluni.

CHAIRPERSON TURNER-BAILEY: Commissioner Ajluni.

COMMISSIONER AJLUNI: I was out of the room. My question is on process, and maybe Jan or staff could answer it. Is it possible that when in the red and the black and we refer it to the committee with the Intention that they would report back to us at the September meeting?

CHAIRPERSON TURNER-BAILEY: We would have to change the timing of what we were given. We told

that committee that they had six months at the time that they were appointed. I suppose we can cut that in half if we wanted to, but I personally don't recommend that.

JAN CHRISTENSEN: But that might cover all concerns and we couldn't be accused of slowing down the process. I think three months is ample time for them to do their job.

COMMISSIONER HAGENOW: So, in essence if we put it to the committee we haven't lost the work of the department, which I think is considerable at many points just by what we heard on two sides. I think it was very interesting what Larry had said, that it was very polarized and it seems to me to be franchise related, full size. How it impacts on their constituency. But the department put this together and that bench should become neutralized in terms of the higher good, go to this committee and be reviewed. The only thing that we'll be sacrificing is time. Am I correct? It's three additional months. Is that a big problem or are we losing something else in this process?

JAN CHRISTENSEN: It is an issue of time. We have a huge crisis in home care in the city. We heard a lot of the testimony today and I won't repeat it, but the Medicaid case load is not covered ground in the future. If anything our best hope would be that it increase slightly and eight or nine months out it'll start to pay along. We have an ugly crisis here. It's not a new issue to this Commission either. It's something that we've been talking about for a couple of years. This particular standard is straight up. It just says on the principle of it that two and a half percent of the beds should be allowed to move. It is available to more than two hospitals. In fact, if only two hospitals applied, you can only allocate 600 beds, and there are 684 beds in this. That's assuming that they applied for the maximum number of beds. So it's more than just two hospitals. How many more just depends on the applicants that applied. So it is a general applicability and I think a strong case could be made of that. We would probably have to make about three or four adjustments on it. I would suggest that you put in the public hearing for public comment. We can come back in September and you can approve or disapprove it at that time. I think at the same time, not crafting language but if you could as a matter of public hearing process ask for the specific recommendations from the specific Standard Advisory Committee. They could say, yes, we like it or we don't like it or whatever. But not asking them necessarily to grant the language. I don't think they're excluded by providing input.

CHAIRPERSON TURNER-BAILEY: But the logistics of that are the public comment hearing will take place when, an approximation?

BRENDA ROGERS: We would have to do 30 days prior to the next meeting.

CHAIRPERSON TURNER-BAILEY: So, around mid-August is when we'll refer this out. By saying that you're saying work that we've asked them to do in six months, they are now welcome to do in six weeks and have a recommendation prepared for the public comment period?

JAN CHRISTENSEN: I wouldn't exactly agree with that characterization. I think what we'll be asking to do is take a look at these two pages within six weeks and say "yes, we can support it as a Special Advisory Committee as individuals or collectively", "no, we can't support it because we have these concerns". I think a Special Advisory Committee is a more broader.

CHAIRPERSON SANDLER: I have several comments to make. First, in terms of a time frame, what Commissioner Hagenow has mentioned, this would be a delay of at least a year in the sense that by the time the SAC comes back, which would be as early as December, and then they'll give us a report and we'll discuss the report. They'll be language based on that which we'll probably get in March, and go through the public comment, and final approval in June. Already you're in June. That's assuming that everybody agrees. So, what is lost is a time frame issue that we were discussing the entire time that you and I have been on this Commission. This would not necessarily be the SAC could make comments as individuals or as a group in August. They could come back with language in December that may not affect this or would affect other public places in the state of Michigan. So, I feel there's no reason why we do not take this to a vote today, to set it for public comment I mean. We have plenty of opportunity to re-access it in September.

CHAIRPERSON TURNER-BAILEY: Commissioner Maitland.

COMMISSIONER MAITLAND: Yes, I disagree. Certainly with going out to public comment, I disagree. I think it should go to the Advisory Committee. Jan mentioned time. The Unity issue with or because of cost, the Unity issue isn't involved in that. It seems to me when we asked if we approved building 600 hospital beds out in the Suburbs today, when would the hospitals get built. I think it's three or four years out. So, certainly it isn't going to solve the state of Michigan's problems in the next six months unless I heard wrong. So, I think six months or three months or four months, whatever it takes to go through the Advisory Committee is time well spent and I can say that I've been on this 10 or 12 years, a long time. We've never had an Ad Hoc and now an Advisory Committee that's ever come back without something that we could work with and get a final solution that everybody agrees with. I think that's the key here. If we go out on public comment on this, nothing is going to change. We're still going to have two sets to the issue. It'll be a disaster in my opinion.

COMMISSIONER SANDLER: Can I comment?

CHAIRPERSON TURNER-BAILEY: Yes.

COMMISSIONER SANDLER: Seeing no one's hand in the air, I would like to call a vote on the motion.

CHAIRPERSON TURNER-BAILEY: All those in favor please signify by raising by your right hand.

COMMISSIONER SANDLER: Someone had to support the motion and they didn't. Not to prejudice anyone's voting on the motion.

CHAIRPERSON TURNER-BAILEY: It was unanimous in any case. There's a motion on the table which has been supported. In fact, I would like to just point out that it was made about 10:20 this morning. The motion is to send the Special Bed Allocation draft language that was presented by the department to be included in the work that was handed in by the Committee's for it's consideration. That motion was supported. Any further discussion? Thank you. All of those in favor please signify by raising your right hand (eight). All those opposed? (Three) The motion carries.

COMMISSIONER MAITLAND: Madame Chairperson, I have another motion that I was thinking about. To try to move this whole thing along and make sure the Standard Advisory Committee gets all the information I guess I would move that the department we authorize or ask, to immediately forward all new proposals, decisions, ideas, correspondence, to the Hospital Bed Standard Advisory Committee so that they can consider all of the information in a timely manner, rather than perhaps bringing something back to us at our next meeting. Just that we recommend sending it onto the Advisory Committee.

CHAIRPERSON TURNER-BAILEY: Any support?

COMMISSIONER HAGENOW: I support it.

CHAIRPERSON TURNER-BAILEY: It's been moved and supported that all interim information data and recommendation relative to bed allocation please be referred to the SAC. Any discussion?

COMMISSIONER SANDLER: Yes, I have a brilliant question. When, I see Mr. Steiger here. When is the SAC likely to give a report so that I know the time frame on the motion? When are you likely to finish and report?

DALE STEIGER: Give a report on what?

COMMISSIONER SANDLER: On your outcome. On your recommendation. On your findings of the SAC?

DALE STEIGER: I haven't the slightest idea. It certainly will be within the time frame that we're charging. Given the fact that we've had no proposals to date except one, which was made after the last meeting that we had. So the last meeting that we had there were no proposals put on the table, nothing to really evaluate.

COMMISSIONER SANDLER: Let's go back to the department and the Assistant Attorney General. They're life, not Mr. Steiger's life, but the life of the committee is six months long, right?

DALE STEIGER: It ends in November. It can be shorter.

COMMISSIONER SANDLER: The latest that this committee would give a report would be the December meeting; is that correct?

DALE STEIGER: That's correct. That's the latest.

COMMISSIONER HAGENOW: I'm questioning--------you don't have a clue when we're coming forward with it. This is the key issue. It's got such vast interest. It doesn't sound like it has much momentum with it, the Committee itself. My biggest concern about all of this is that there's a lot of work going on here, and is this Committee now going to take action and bring the recommendation in a timely fashion? If possible it should be shorter and not longer. That's clearly the issue that's keeping ------we jeopardize the CON more so by these delays then we do by the fact that we say that it's going to go away if we don't take a stand.

DALE STEIGER: My understanding from Mike's question is that he would like me to say that they were going to deliver something on August 15th.

COMMISSIONER SANDLER: August 15th is not a public comment section. You would be delivering it to a relatively empty room there. The December meeting.

CHAIRPERSON TURNER-BAILEY: The six month time frame is really final. We've asked the Committee to come back to us within six months. That doesn't mean that they can't come back before six months. We would really like to see something before six months, but they do have the six month time frame that we've given them.

LARRY HORWITZ: I'm not a member of the SAC. You clarifying it significantly helped resolve and move forward the work of the SAC; why is that? Because when they were there they were told by staff that was uncertain as to whether or not these very issues that you have before you today is something that they should even deal with at all. So, the question is what were they supposed to deal with? There's a dispute over what the charge was. It passed Mr. Maitland's motion and the second one declared by that. Number two, there's supposed to be dealing with the suggestions and recommendations of the department about database -------unfortunately the department wasn't able to come forward with it. That's the reason why the first meeting was held in late May and they had to cancel the second meeting, still awaiting the Department Provision of Data and guidance from you. The department indicated that on the meeting on the 22nd they could have the data, you provide the clarity. You've now for the first time given the committee a basis of what they're supposed to do in order for this to go forward. I don't know whose on the committee off hand, but these
are apparently people that the department thought were good people.

CHAIRPERSON TURNER-BAILEY: Is there any discussion on the motion? All those in favor, please signify by raising your right hand. (Eight) and opposed (one) the motion carries. Thank you. We have a couple of more speakers. It's important to hear them. The next item on the agenda is the Unity Health Discussion Table for May. I for one ------that was done. We can have another motion to take that off the table. Ashley Care Center.

MR. STEIGER: They had to leave.

CHAIRPERSON TURNER-BAILEY: Give them my apologies. The next item on the agenda is the report from the Standard Advisory Committee. I actually think we received this in large part. Mr. Steiger.

DALE STEIGER: I'm Dale Steiger with Blue Cross/ Blue Shield of Michigan. I'm not the cheap part of the planet. We'll make this very quick. We had an initial meeting on May 25th. We had hoped at that point that we would have proposals from someone. We did not, so we had to put general discussion as to where

things needed to end up. The department has suggested that we could work with the geography department at Michigan State to develop some sort of a population piece, a bed need methodology. As you can recall, well, we've been working with for the last couple of years is a utilization based bed need methodology. I think we need to go further with that, so Bill has suggested that we bill as a medical geographer. From what understand they've offered to work with Michigan State. I believe Bill has already had one meeting with the geography department over there. There's another meeting set up for the next couple of days. We continue to see what happens with that. I don't want to give you the impression that this group is not working. We had a meeting on May 25th. We had another meeting scheduled and it was felt at that point that we didn't really have enough substantive stuff to go over, so the meeting on June 10th was canceled. We have a meeting on June 22nd. Hopefully we'll be able to go over some of this material for Michigan State and they'll have the other items that are on the floor today. I am going to keep the Commission informed. As we go along we're not just trying to make reports. As you can recall I sent a summary of the last meeting several days after the group met. We also sent out a proposal that was made. Isaid there were no proposals at the meeting, but there was one proposal given to me three or four days after that meeting. That proposal for geography based, population based, access bed methodology was sent out to everyone along with my meeting summary. So we hope to as soon as the minutes are prepared for these meetings, we hope to get the summary meeting minutes out to everyone so that there aren't any surprises. I'll be happy to answer any questions.

CHAIRPERSON TURNER-BAILEY: Thank you, are there any questions? Commissioner Hagenow.

COMMISSIONER HAGENOW: What I understood the greatest issue was around the geography and the fact that the population has changed and how you're going to address that, I think is what I'm keenly interested in. That along with now this access question that is coming here to that committee, I'm looking for the fact that you do rise above constituency and look for principle that everyone of us can understand, rather than it is going to keep this person out of the market or that person in the market.

DALE STEIGER: That's why I think it's important that when Bill came forward with this geography based bed methodology, we were severely criticized for the last bed need methodology go around. Rational basis issues, and I think we want to avoid those kinds of questions with the work that we do in the next four and a half months or so.

COMMISSIONER HAGENOW: I just wanted you to clarify the charge and make sure you found it the same way.

DALE STEIGER: I think you're aware that Marie pointed us or is the liaison between the Standard Advisory Committee and Bill is working with Michigan State. Thank you.

CHAIRPERSON TURNER-BAILEY: Thank you, any further questions. How much can I cut out. I'm ready to go to public comment; is that okay? Do I need to do a motion for that.

COMMISSIONER GOLDMAN: Did you want to say anything about the bylaws?

RON STYKA: I just want to say that we did a lot of work in the bylaws, however because we're still waiting for the official opinion from the board, although I gave you today a graph that I put together based on a motion that I have, it could get modified, so we're not really ready to do bylaws, but we will at the next meeting. There will some things in there that you will have to decide whether or not you want to keep them in or not.

COMMISSIONER GOLDMAN: You've got comments from people.

RON STYKA: I have your comments, the department did a lot of work on it. We do our Commission's report.

CHAIRPERSON TURNER-BAILEY: Thank you, are there any questions. We just finished the by-laws status report, and now we would like to go to the public comment. Dorothea Wilson.

DOROTHEA WILSON: Hello, and thank you very much. I'm Dorothea Wilson from The Lighthouse, which is a sterile rehab facility. We're not in an urban area but a rural area, very rural. This is for a request for the exception to add 10 to 12 ventilator beds. On August 7, 1978 at 3:30 in the morning, my son suffered a severe traumatic brain injury. Because of that we started our own rehab. Today we have 80 adult beds and 20 pediatric beds. We have 17 years experienced, we're fully licensed, we're CARTA credited. We have a continuum of care for medically stabled right on through being independent in the community. The missing component for us is the ventilator beds and we would like to be able to have just 10 to 12 so that we might be able to go right from the hospital right on through, and be able to do it. We have a terrific co-step program. We already have 29 professionals on the board. The need has been expressed by case managers several times, and I do have a small letter that I want to read by Respiratory Therapist. This letter is in support of the Steel Facility, Lighhouse in Caro, Michigan for the opening of the new wing for ventilator rehab. I'm a practicing registered Respiratory Therapist and I see many people who will benefit from this type of facility. Typically the waiting list is long for facilities like this which adds to the frustration of families, as they are given options that may not have been their first or second choice. This board that I led to the Lighthouse is for the sake for the families and their loved ones that would be cared for them. I have worked with Lighthouse as well as served on the staff. The care is excellent and the facility offers the extensive physical rehab services. By allowing Lighthouse to extend their care to patients with higher needs will help to relieve the waiting list that is always present with these types of patients, as well as providing the patient and family with the facility that has an outstanding core value. I just want to add one other thing. That our families that are in the thumb area, and that's where we are at in case you don't know where Caro is. The fact that they have to drive at least two or three hours to get to some place that would have a ventilator, and it does snow a lot there. One other thing that I wanted to say is that we do serve with excellent care because it is ran by a mother.

CHAIRPERSON TURNER-BAILEY: I'm sure that's absolutely true. How do you spell Caro?

DOROTHEA WILSON: C-A-R-O.

CHAIRPERSON TURNER-BAILEY: Are there any questions?

LARRY HORWITZ : We have spoken with this issue. Our nursing home reviewer has talked, but unfortunately there are no ventilator beds in the pool. At this point and time the Commission will review the special pool beds. So there are no ventilator beds. Unfortunately in the county that their in there are no access or available nursing home beds that can be designated as ventilator beds. We will continue to try to work with the facility. We are hoping soon that our bed inventory will be out on the web and you get updates monthly. If somebody de-licenses nursing home beds, that they will be available by October.

COMMISSIONER CORY: I have some experience on this area, and it's a frustrating situation when the beds aren't there. In the Upper Peninsula of Michigan for example that encompasses 15 counties, there are no ventilator beds and there is no medical care facility that will accept bed ridden patients. There aren't too many because it's a huge need issue. It's a high intensive care and it's usually a losing situation. However, a question to you. You entered into a special memorandum of agreement with the state to provide extra limited beds?

DOROTHEA WILSON: Usually our sources come from the no-fault insurers. We're Medicare and Blue Cross but we are not Medicaid because we haven't been able to afford Medicaid at this point.

COMMISSIONER CORY: Are you a skilled nursing facility?

DOROTHEA WILSON: No, we are licensed as an adult foster care, childcare institution.

CHAIRPERSON TURNER-BAILEY: Thank you, Kathleen Maine.

KATHLEEN MAINE: Good afternoon Commissioners. I think I'm the last one. My name is Kathleen Maine and I'm an attorney with Barnum Law Firm. We represent a group of hospitals and health systems, Botsford, Beaumont, Covenant in Mt. Clemens and Trinity Health who have a legal challenge of Public Act 619 still pending before a judge here in Lansing. We would like to commend the Commission and it's

Chair, Mrs. Turner-Bailey who are seeking guidance on the issue of conflicts that the insurance around this state or the ethics and I noted today particularly the high degree of sensitivity on this issue, and questions aimed towards to Mr. Styka related to specific issues coming up. We do appreciate that. The issue of conflicts of interest, now that the Commission is contingency based, has become a more significant issue. It continues to be a matter of concern to these hospitals as items like hospital bed standards that are being considered. So, we would simply urge the Commissioners and Mr. Styka to continue this diligence. Carefully review the commitment of the State Board Ethics when it becomes available and carefully consider whether the standards are specific to certain institutions or whether they are truly gentle or applicable when they come up in the future. Thank you very much.

CHAIRPERSON TURNER-BAILEY: Thank you. Any questions?

COMMISSIONER SANDLER: I have two comments to make. One to Commissioner Maitland, who I understand is the liaison on the radiation therapy issue. I did furnish the department with three names; a Radiation Oncologist that will be happy to help as an expert or a consultant on this area. I had mentioned that at the last meeting. They do have that material. Second, did you get a letter from Lakewood hospital? The second issue concerns PET standards. There's been a concern expressed, not to the high quality of pet standards, but from a technical issue consuming a machine in HSA, things like that. I've been asked to participate in a word group as a Radiologist and we'll look at only these technical issues. This is not something else. I just wanted to clarify that.

COMMISSIONER MAITLAND: Are we establishing then another work group for Dr. Sandler?

COMMISSIONER SANDLER: It's a four hour at the most and that's it.

COMMISSIONER MAITLAND: One of the reason that we haven't started is because of the work load of the department. You want to tell me to start working but then you keep adding things.

COMMISSIONER SANDLER: It's up to the department to decide when this would take place. Brenda, you don't have to do it in order of importance.

CHAIRPERSON TURNER-BAILEY: With that I'll set the motion for adjournment.

COMMISSIONER HAGENOW: So moved.

CHAIRPERSON TURNER-BAILEY: Thank you, we are adjourned.

(Whereupon proceedings concluded @ 4:05PM)